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COMMITTEE ON HEALTH AND HUMAN SERVICES
January 18, 2006
LB 766, 833, 838, 908, 882

The Committee on Health and Human Services met at 1:30 p.m. on Wednesday, January 18, 2006, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB 766, LB 833, LB 838, LB 908, and LB 882. Senators present: Jim Jensen, Chairperson; Dennis Byars, Vice Chairperson; Doug Cunningham; Philip Erdman; Gwen Howard; Joel Johnson; and Arnie Stuthman. Senators absent: None.

SENATOR JENSEN: Welcome, ladies and gentlemen, to the first hearing of the Health and Human Services Committee. We want to welcome each one of you. I'll just briefly explain some of the procedures that we will follow as we move through the hearings. First of all, if you are carrying a cell phone, please shut the ringer off. These proceedings are transcribed, recorded, so the transcriber does not appreciate that ringing in her ears. Then, also, as you come up to testify, there are some sign-in sheets here at the table. There are some over there also, on a table over there. Fill that out. When you come up, slip it into the box on top of the table. Then identify yourself, spell your last name for us so we have correct spelling, again on the records. Let us know if you are testifying in your own behalf or on the behalf of an organization. If you have handouts, the correct number is how many, Joan?

JOAN WARNER: Twelve.

SENATOR JENSEN: Twelve. If you don't have that many, we can run off some more. I am going to ask that if you are testifying and if you have a sheet that you're reading two pages, that's enough. And if it's more than that, please condense it so that we can move through the hearings fairly rapidly. Again, this is bill introduction time and many of the senators are in other parts of the building introducing bills at this time. I will introduce you to the senators that are here at this time, and any others that come in I'll introduce those also. To my far right is Senator Cunningham from Wausa, Nebraska; next to him is Vice Chairman of the committee, Dennis Byars from Beatrice; to my immediate right is Jeffery Santema who is the committee counsel; I'm Jim Jensen serving as Chairman from Omaha; to my left is Joan Warner who is the committee clerk; next to her is Joel

Johnson from Kearney; and next to Joel is Senator Arnie Stuthman from Platte Center; and Senator Howard is also here getting ready to introduce the first bill. With that, I think we are ready to begin the proceedings for this year. Senator Howard, you may proceed. Oh, one other thing. On your sheet I did have that we would have a joint hearing between LB 838 and LB 908. We will hold that hearing separately. So the bill introducers will each introduce the bill. We'll hear testimony on it and then we will close and open up the next bill rather than doing one joint hearing. So we'll begin with LB 766. Senator Howard.

LB 766

SENATOR HOWARD: (Exhibit 1) Thank you, Mr. Chairman and members of the Health and Human Services Committee. For the record, I am Senator Gwen Howard and I represent District 9. I thank you for this opportunity to introduce LB 766. The purpose of this bill is to ensure the health and safety of children who are wards of the state of Nebraska. Psychotropic behavior-modifying medications act primarily on the central nervous system. They are designed to be used in the treatment of mental or neurological disorders. LB 766 respectfully requests that the Health and Human Services Committee establish a task force to evaluate the state's policy for prescription of psychotropic drugs to state wards, and their process for monitoring the use of these drugs by state wards. I'm asking that a task force carefully consider what limits should be placed upon the psychotropic drugs prescribed to state wards and to make recommendations regarding policy. During the interim, my office conducted a study in which we examined the numbers of state wards that were prescribed psychotropic drugs. This study uncovered some startling information. In 2005, according to the information provided by Nebraska Health and Human Services, 3,107 of 7,503 state wards, or 40 percent, received 42,405 prescriptions of psychotropic medications costing the Medicaid system more than $4.6 million. That represents a slight increase over 2004 when 2,925 of 7,164 state wards received 39,832 prescriptions of psychotropic medications costing the Nebraska Medicaid system more than $3.9 million. While I'm aware that there are certain instances when children have illnesses or conditions that

require pharmaceutical treatment, I'm concerned that the number of state wards being treated with these powerful drugs in Nebraska is too high. The extensive use of psychotropic medications among Nebraska state wards is alarming for several reasons. High caseworker caseloads and caseworker turnover challenge the state's ability to monitor behavioral changes or side effects that result from psychotropic medication use. Providers who care for children with behavioral, medical, emotional, or cognitive disabilities that require these medications qualify for higher levels of care reimbursement. I believe that can make these providers less objective when they are determining whether these medications are a necessary component of treatment. Psychotropic drug therapy is generally a less expensive and less time consuming modality than talk or cognitive behavior therapy creating yet another bias that can lead to misuse of these drugs. When children are placed in the temporary custody of the public agency pursuant to a court-dependency proceeding, the question of who has the right to consent to prescriptions of psychotropic drugs on the child's behalf is unclear and parents are not consistently involved in these decisions. Many of these psychotropic medications prescribed for behavior modification are not indicated for pediatric use, and children who are prescribed medications in lieu of nonpharmaceutical therapies do not learn how to control their own emotions or behaviors without the aid of medication. Since 1999, at least 22 states have passed bills or resolutions relating to the prescription of psychotropic medications to children. We owe it to the children whose care is entrusted to the state of Nebraska to be cautious when it comes to prescribing and administering psychotropic drugs to treat them. I believe that it is time that we seriously examine the situation and set clear boundaries to ensure that we are not creating a lifetime of damage for these children in order to find temporary solutions to their behavioral and psychological challenges. I would ask for your favorable consideration of this bill.

SENATOR JENSEN: Thank you, Senator Howard. Any questions from the committee? Senator Stuthman.

SENATOR STUTHMAN: Thank you, Senator Jensen. Senator Howard, do you feel that the majority of these psychotropic

medications are for behavioral purposes?

SENATOR HOWARD: Yes, I do.

SENATOR STUTHMAN: And it is a way of medication instead of caretaking involvement to try to get these children, you know, respectable?

SENATOR HOWARD: In my opinion and in my experience, it's a way of controlling behaviors rather than addressing underlying causes.

SENATOR STUTHMAN: In other words, this is just a simple control method?

SENATOR HOWARD: An easy and simple control method, yes.

SENATOR STUTHMAN: And easy. Okay. Thank you.

SENATOR JENSEN: Any other questions? Thank you, Ms. Howard.

SENATOR HOWARD: And I have three testifiers.

SENATOR JENSEN: Okay. And I didn't mention we do take proponent testimony first, and then we take opponent testimony, and then we take neutral testimony if there is any. So at this point in time, we are ready for proponent testimony, and you have some to follow you.

SENATOR HOWARD: Thank you.

SARAH ANN LEWIS: (Exhibit 2) Good afternoon, Senator Jensen, members of the committee. My name is Sarah Ann Lewis, L-e-w-i-s, and I'm here on behalf of Voices for Children in Nebraska in support of LB 766. Today we heard from Senator Howard of the rather extraordinarily high numbers of state wards who are being prescribed psychotropic medications. Because these are prescriptions that require close monitoring, we have serious concerns about the prescription and administration of these drugs to children in the state's care. At Voices we have heard stories from foster parents who have taken in foster children they described as full of life and energy. The foster parents

later learned that these same children were supposed to be receiving prescriptions for these medications. After filling the prescriptions and administering the drugs, the parents described the children as becoming a shadow of their former selves, lifeless, and zombie-like. Conversely, we have received reports from agencies of children in placements who go without these prescriptions for days and even weeks who require these meds to maintain a better quality of life. Anecdotally, we know we have a problem. We believe the implementation of policy to properly prescribe and administer these prescriptions is in order and we appreciate the attention Senator Howard and the Legislature are giving this issue. And thank you for giving this bill careful consideration.

SENATOR JENSEN: Thank you, Sarah. Any questions for Ms. Lewis? Thank you for your testimony. Excuse me. Senator Stuthman had a question.

SARAH ANN LEWIS: Oh, sorry.

SENATOR STUTHMAN: Thank you, Senator Jensen. Sarah, do you feel that prescribing and the administration of these drugs, the children get dependent on the drugs or do the foster care parents depend on those drugs to control the child?

SARAH ANN LEWIS: I think it's a case-by-case basis. I do believe some of these children are receiving these drugs appropriately to maintain a quality of life. And I have concerns about a system that will pay a foster family more for a child that's diagnosed as having a behavior disorder, so that they are receiving these medications. And do they become dependent upon them? I'm not sure. If they remain on them too long, they may feel a sense that they wouldn't know how to live without without them, which would be unfair in the case they're receiving them unnecessarily.

SENATOR STUTHMAN: Thank you, Sarah.

SARAH ANN LEWIS: Um-hum.

SENATOR JENSEN: Any other questions? Thank you.

TAMMY PETERSON: (Exhibit 3) Senator Jensen, members of the

committee, my name is Tammy Peterson, P-e-t-e-r-s-o-n. I'm the Omaha area supervisor for the Foster Care Review Board and a former Child Protective Services worker. LB 766, introduced by Senator Howard, provides for a task force to study the prescription and administration of psychotropic medications to wards of the state. I'd like to, first of all, thank Senator Howard for bringing this issue to the forefront. Even with good care and stability of placements for many children, psychotropic medications may be necessary. For some children, however, there is question as to whether or not increasing the stability of their living situation and/or placing them in a specialized treatment trained to handle their particular behavior might be a better option. The Foster Care Review Board, through its reviews, has identified many children who are on behavior-modifying medications. There is often a misconception that these medications are only given to rebellious teenagers. That does not reflect the reality for the foster care population, as evidenced in the following example: Sally, age 4, Joseph, age 5, and Adam, age 2, were all prescribed psychotropic medications including Concerta, Medadate, Clonidine, and Risperdal. These medications are given to address behavior such as hitting, biting, and scratching. The children were not involved in any type of behavior modification program, and then the board recommended that this behavior modification program occur. Since this behavior modification, the foster mother for these children have reported a significant improvement in the children's behaviors. The Foster Care Review Board has noted some issues related to psychotropic medications as well. Some behaviors, of course, can be extremely challenging to deal with, requiring more group home staff or support for foster parents who care for the children. Sometimes the treatment children receive while in care can add to or create behavior problems, such as when children experience an excessive number of moves, which we know happens to about 47 percent of children in care. Medicaid pays for drug therapy but provides limited reimbursement for psychiatric evaluations, thereby creating an incentive to treat behaviors with drug therapy. Sometimes medications may be prescribed in the absence of an actual psychiatric diagnosis and are merely used to see if they work. Some medications are given to some very young children and, as Senator Howard had pointed out, many of the atypical and

antipsychotics have not been approved for pediatric use, so there are no dosing guidelines. Some children who are on behavior-modifying medications are also on medications for physical ailments such as asthma. In such cases, professionals prescribing these medications need to be in constant communication with each other. Just as children have individualized medical treatment, children need to have individualized treatment for their behaviors. There will always be some children who, due to their individual make-up, need certain medications in order to thrive. Yet, medications are not a one-size-fits-all solution. If children are to have successful outcomes, it's vital that professionals involved in children's cases, and their caregivers, respond appropriately to our state wards' need for medication. I'd like to thank the committee for focusing on this very critical issue, and would be happy to take any questions.

SENATOR JENSEN: Thank you, Tammy. And thank you for shortening your testimony. (Laughter) I noticed that you did...

TAMMY PETERSON: Yes (laugh). I did, yes, I did.

SENATOR JENSEN: Yes. And I do appreciate that. All of these drugs, however, have been issued through a prescription from a doctor, correct?

TAMMY PETERSON: Correct.

SENATOR JENSEN: And so if we challenge that, we are challenging the doctor who prescribed those drugs.

TAMMY PETERSON: Well, I think that's a great point. But I think what we're actually challenging is thinking differently about how we address the issues. As in the example that I gave you of the three children that were on medicines, yeah, we could give them the psychotropic medications. And truthfully, they'd stop scratching, biting, and doing all those other behaviors. But once you take a look at really what are the underlying issues as to why the children have these behaviors and address those underlying issues, that's what's going to help the children ultimately. They don't need the medications. Let's deal

with the behaviors, you know, and get a handle on those behaviors and, thereby, we don't need the medicines anymore. So, yeah, it is challenging that but I think it is something we need to do.

SENATOR JENSEN: The only thing is we don't see the behavior modification on TV as to...

TAMMY PETERSON: That's true.

SENATOR JENSEN: ...take this drug and you'll be well in 30 minutes.

TAMMY PETERSON: That is true. And as Senator Howard also mentioned, it is a little tougher in that you have to...you know, it's a pretty intensive behavior modification. It's not going to be a quick fix. You know, it's not today the behaviors are there, tomorrow they're different. But ultimately it is in the benefit of the child because it is addressing, as we said, those underlying issues and taking care of those.

SENATOR JENSEN: Thanks, Tammy.

TAMMY PETERSON: You bet.

SENATOR JENSEN: Any questions? Yes, Senator Stuthman.

SENATOR STUTHMAN: Thank you, Senator Jensen. Tammy, do you feel medications is more of a Band-Aid approach to a behavioral problem rather than an educational or training of the children?

TAMMY PETERSON: Great question. I think, you know, from what we have seen through our reviews, predominantly yes. Now I don't want to say that's...you know, as I mentioned in my testimony, there are some children who do need psychotropic medications, absolutely. I don't think anybody's going to question that. But we do see that it is pretty readily prescribed and, again, with foster parents and other placements, we'll find that children will be prescribed this medication to say, here's the behaviors, let's fix it with medication rather than, as I mentioned, let's look at the underlying issues and try to adjust those.

SENATOR STUTHMAN: Thank you.

SENATOR JENSEN: Yes, Senator Byars.

SENATOR BYARS: A question. I know that's what Senator Howard wants to do is study the issue and find out what we're doing, what we should be doing, and how we get from here to there. But just a question, from your expertise, where are we falling down in public policy and how, from a public policy standpoint, can we control this when we're dealing with family members who find it easier to drug their kids, we find foster parents who find it easier to drug kids, we find out-of-home placement of state wards and out-of-home placement situation in foster homes or in group homes, how do we get our arms around this from a public policy standpoint that makes sense?

TAMMY PETERSON: That's the question of the hour. I think, from my professional experience, what I feel and what I believe, is that with regard to children in the system, and there are over 6,000 at this point in the system, and through our reviews we as a body of knowledgeable responsible, citizens of this state need to be more responsible with our state wards, with all of our youth but our state wards. And I will tell you, Senator, in my experience I'm seeing children just...psychotropic medication is used as a quick fix. And we just, we have to be more responsible with that. As far as the policy and how do we embrace that? That's a great question. I leave that to senators to look at but I do think again, I believe, based on what I've seen, I've seen the children, I've seen the zombied looks on their faces. You talk to any educator who sees children who are given the medication and it's disturbing. So I think we have to take a look at it.

SENATOR JENSEN: Thank you.

SENATOR BYARS: Thank you very much.

TAMMY PETERSON: You're welcome.

SENATOR JENSEN: Any other questions? Thank you for your testimony.

TAMMY PETERSON: Thank you.

SENATOR JENSEN: Next testifier please? Hi.

CYNTHIA ELLIS: (Exhibit 4) Good afternoon. My name is Cindy Ellis, E-l-l-i-s, and I'm an associate professor of pediatrics and psychiatry at the University of Nebraska Medical Center. I'm here today speaking on my own behalf as a physician rather than as a representative of UNMC. My training is in pediatrics and child psychiatry, and I'm board certified in behavioral developmental pediatrics and neurodevelopmental disabilities. In my clinical work, I evaluate and manage children with a wide range of emotional, behavioral, and developmental disorders including a large number of children on psychotropic medication whom I'm providing that prescription for. And in the context of doing this work, I have the opportunity to participate in the care of a large number of children in foster care who are wards of the state. I appreciate the opportunity today to speak in support of this proposal to review the use and the policies regarding psychotropic medication use in children who are wards of the state. As you'll hear, I'm very supportive of the use of psychotropic medication as an appropriate and sometimes effective mental health treatment for children. But I share the concerns of Senator Howard that we don't possibly have all the current policies and procedures which really support the best practice for psychotropic medication use in this population. To kind of put it in context, we know that children who are in foster care have a lot of risk factors, biological risk factors, psychosocial, psychological risk factors, and thus they have a higher rate of complex mental health problems. So it's not unexpected to see a larger number of kids with mental health problems in foster care than you would in the general population. We also know there is a number of major challenges to providing high quality mental healthcare for these children. Their medical services and their mental healthcare is often very fragmented, and there is frequently not resources available for evaluation and treatment in general. And even in certain areas of the state, particularly rural locations, there may be even fewer resources available. We know that over all, the use of psychotropic medication in children is increasing in

general. A number of factors related to this, one, as you mentioned, was the increased knowledge of the public regarding the availability of medications from direct to consumer advertising. We also know that there's been an effort to identify and treat kids with behavioral and psychiatric disorders, and so we're now finding more of those kids who we can offer support for. Some of the increased use of medication is based on some recent evidence that many psychiatric developmental disorders have a biological origin, that there are biological factors that are associated with the disorder and so a biological treatment would be a kind of a nice fit in many cases. And we also know that there is some emerging research evidence for the use of psychotropic medication to benefit kids with certain psychiatric disorders. And I feel very strongly that some children, many children benefit from psychotropic medication as a part of their treatment plan but it's in the context of a larger treatment plan that includes social, psychological, behavioral treatments, educational interventions. Medication is considered a first-line treatment for ADHD, which is a very common behavioral disorder. But for most other disorders and most other target symptoms, medication is not a sole treatment or a primary intervention. Medication is considered to be one component of a treatment plan. But medication is often a very valuable part of that treatment plan that can really improve a child's functioning, decrease their symptoms, and then allow those other treatments that we know about to be more effective. In my experience, I've seen a lot of kids who are undermedicated, a number of kids who are overmedicated like the children we heard about, and then I see a large number of kids who are really appropriately medicated but their change in situation, their change in stress, their move to foster care has required that there needs to be some changes and some modifications in their medication. And that really demands appropriate evaluation and monitoring. There is some research now that we're just beginning to see over the last several years that shows the efficacy or the benefit of psychotropic medications in the short-term treatment of a number of child psychiatric disorders. As a physician, we would take that research evidence plus the data from adult studies, and there is a lot more of that, and then clinical experience which is often published in the literature or from colleagues. And

we use that to make medication decisions. And although we need more research, a number of physician organizations such as the American Academy of Pediatrics and the American Academy of Child and Adolescent Psychiatry have developed some clinical practice guidelines for the use of psychotropic medication in children. And we know that implementation of these guidelines and procedures by physicians increases the benefit and safety of psychotropic medications, and it also reduces ineffective and inappropriate medication and medication combinations. Effective medicine management really requires an appropriate diagnosis, identification of the target symptoms, education of the patient, the caregivers, obtaining informed consent and having someone that is qualified to help implement the treatment, and then developing a treatment and monitoring plan and implementing that. As physicians, we base our treatment and our decisions on the information that comes to us and so often we don't get accurate information, we don't get continuous information, if the chain of custody of that child hasn't been continuous. And it's really important that the caretakers and the other professionals who are giving us information about the child has a knowledge about that child, about mental health disorders, and about the medications so that they can provide us with effective and helpful treatment. Because otherwise, we're basing our decisions, which we have to make, on maybe what's not good information. As with any medication, psychotropic medications can have side effects. And the nature and the severity of the side effects really vary across different medications. Some of the side effects can be managed pretty easily by adjusting the dose or the medication; however, some of these side effects are severe and potentially dangerous. And that means that this is really a careful decision that really needs to take that into account. I really believe that the appropriate use of medication is a medical decision, and I think it's based on a comprehensive diagnosis and then an assessment of the risks of those medications versus the potential benefit that they offer to the child. And then you make that on an individual case-by-case basis with a competent physician in collaboration with the child's caretakers who have some knowledge about what they've seen and what they would like to see happen in the future also. Kind of in summary, as guardians of these children as mental health professionals,

it's our responsibility to ensure that they get effective treatment of their mental health disorders but that they also remain safe. As a pediatrician, one of my concerns, Senator Howard mentioned, that this is not a Nebraska issue, that this is a nationwide issue. And I think the medical community has some concern that in attempts to really assure safety and to have sufficient checks and balances, that inadvertently we may reduce access or delay the timeliness of the provision of psychotropic medications. And that also would not be good. I think that the development of this task force and some policy suggestions as we talked about and some recommendations would be very important to really support the safe and effective use of medication in this population in the context of comprehensive mental health services.

SENATOR JENSEN: Thank you, Doctor. You are a educated, skilled, licensed professional.

CYNTHIA ELLIS: Um-hum.

SENATOR JENSEN: And if a caseworker or if a foster care review individual were to write you a letter and maybe question your prescribing a medication on a child, how would you take that?

CYNTHIA ELLIS: You know, that happens all the time. And we really welcome that because that tells us that somebody is interested and somebody is thinking about the issues. You know, that does happen that we will make decisions and some of those decisions are made in the context of the information we have with the parents and the caretakers and the information they have, and that just tells us there is other information to bring in, and to enlarge that body of knowledge that we use to base these decisions on. So we generally welcome that and really try to bring in information from as many sources as possible to see what would be the best overall decision. And often it's not to use medication. One important concept in medication management is reducing medication when the child is doing well, having a plan to get them off medication.

SENATOR JENSEN: So perhaps as a result of this, it might be...one of the biggest things would be a communications

factor between the physician and the caregiver and the caseworker.

CYNTHIA ELLIS: I think that's one...when we talk about policy implications, that's one of the big ones is to provide some consistent historical information: symptoms, what's worked in the past, what treatments have happened in the past and then to have some good chain of command for who can provide consent. And so I think regarding policy, that's a big part of it.

SENATOR JENSEN: Thank you. Senator Byars.

SENATOR BYARS: I couldn't agree more. And I think to add to that is on a follow-up, an ongoing basis, not only diagnosis leading to the issuing of the prescription or the diagnosis but what's happening afterwards, the communication factor from the service coordinators, the careworkers, the foster parent, and the parents, back to the physician. And that might be where we can require some communication on a public policy basis.

CYNTHIA ELLIS: And I think, in addition to the communication, there needs to be some training; that you can't get adequate and helpful information from someone who doesn't know what you're looking for. And so they have to have some knowledge of what to expect, what to look for, which is a training issue. And I think that's a training issue for foster parents and caseworkers but also for some physicians and mental health providers. You know, one of the things I didn't talk about in my testimony was the real lack of competent psychopharmacologists in Nebraska. There's less than 20 child psychiatrists and only four behavioral pediatricians in the state. And we are really those who are the most skilled in this. That's not enough to see everyone, and it's not enough to provide consultation on even the most complex cases. So we need to provide some ongoing training for all mental health workers regarding medication.

SENATOR JENSEN: Any other questions from the committee? Thank you very much for your testimony. Next testifier as a proponent? Any other proponent? Opponent testimony? Anyone in opposition? Neutral testimony?

MARY STEINER: (Exhibit 5) Good afternoon, Senator Jensen and members of the Health and Human Services Committee. My name is Mary Steiner, S-t-e-i-n-e-r, and I am the Nebraska Medicaid Director with Health and Human Services System. I'm here to testify in a neutral capacity on LB 766. I would like to give you some information about our current and proposed oversight of the Medicaid pharmacy program for behavioral health drugs. The decisions regarding prescription drugs are made in Nebraska by the treating physician in consultation with the patient, family, or patient representative. There is consultation and assistance available to the physician and family. However, under the current Magellan Behavioral Health Contract, 20 to 30 care conferences to review all aspects of the client's current situation are conducted every week. Care conferences are triggered in a variety of ways. These care conferences for children involve the physician, family or the legal guardian, caregivers, caseworkers, counselors, program staff, and a child psychiatrist. The majority of the care conferences are about children, with 90 percent of those being about state wards. During these reviews, all aspects of care including medication regimens are included. Particular attention is given to any child under five years of age that is receiving any type of psychotropic medication. An example of an outcome of a care conference for a child that is not doing well and who is taking a large number of medications, like five or six, is for a recommendation that the child be hospitalized and have all medications stopped. Medications are then restarted one at a time. Many other situations are reviewed with many possible outcomes and recommendations. We also have plans to do more to assist treating physicians. The Nebraska Medicaid Reform Plan, dated December 1, 2005, indicated that the fastest growing expenditure category in the Medicaid program is prescription drugs. And the drugs used to treat mental health disorders are among the highest cost and fastest-growing classes of drugs within the pharmacy program. While the average increase in the drug expenditures over all in the past five years has been over 13 percent with growth in mental health has been over 16 percent during the same time period. One recommendation from the Medicaid Reform Plan, which we are proceeding to implement, is to adopt a program similar to the Missouri

Mental Health Medicaid Pharmacy Partnership Model to improve the use of drugs to treat mental health conditions and to control Medicaid spending. This approach does not rely on prior authorization or state requirements but uses monitoring and education of prescribers regarding best practices. The program identifies inefficient and ineffective prescribing patterns based on evidence-based best practices standards for mental health drug therapy. One of the strengths of this program is its flexibility. First, trained professionals, including the treating physician, have the benefit of current research and the benefit of the particular needs of the patient to guide a treatment decision. Second, as research demonstrates new best practices, the program keeps pace. This model looks at mental health drugs used across all age groups, prescribers, and drug classes. Mental health drug use by state wards will be an important part of the strategy. The department is in the initial stages of forming a communication network with partners. Initial conversations have been held with the Nebraska Medical Association, the Nebraska Pharmacists Association, Magellan Behavioral Health, and the managed care psychiatric consultants. Testimony during Medicaid reform hearings made us aware that advocacy groups and other providers have an interest in this as well. As described in the strategies in the Medicaid Reform document, during the current fiscal year we will review the research on best practices and work with others to identify best practice standards for prescribing mental health drugs. Beginning next fiscal year, HHSS will analyze data on current prescribing practices and compare them with the best practice standards. Based on that analysis and with our partners, best practice and screening standards for some mental health drugs will be established. Following that, the determination of whether to issue a contract or to manage this program within the existing structure and processes of the Medicaid program will be made. As a separate but related issue, the Medicaid Pharmacy Point of Sale system, which adjudicates claims for the pharmacies in real time, contains a number of edits to help assure appropriate drug utilization. These edits are based on industry standards and on the FDA-approved indications for drugs, including age-appropriateness, daily dose, duplication, therapeutic duplication, and others. The department's professional staff along with the Nebraska Drug

Utilization Review Board are responsible for establishing and maintaining those edits. I would be happy to answer any questions.

SENATOR JENSEN: Thank you, Mary. Any questions? Yes, Senator Byars.

SENATOR BYARS: Thank you, Senator Jensen. Your percentages that you used as far as average increases, Mary, are those annual increases?

MARY STEINER: Yes.

SENATOR BYARS: Okay, and that's not 13 percent for five years but 13 percent annually?

MARY STEINER: No. Sorry to say that, no.

SENATOR BYARS: Okay, thank you very much. I appreciate your testimony.

SENATOR JENSEN: Yes, Senator Stuthman.

SENATOR STUTHMAN: Thank you, Senator Jensen. Mary, in your discussion on the best practice standards, is there any part of that where there is no medication? Is there any component of that, you know, best practice standard...to me that means the amount of medication and which medications...

MARY STEINER: Um-hum.

SENATOR STUTHMAN: ...and everything like that. I'm trying to get to the point where no medications and work with teaching, education, environment, and family.

MARY STEINER: Yeah, right. We haven't reviewed all of those. However, I know in the Missouri model they did go through their paid claims to identify certain drugs that weren't appropriate for very young children. I mean, that being an example that, you know, those children shouldn't be on those drugs as opposed to another review might include you shouldn't be on more than one or two of a certain type of drug. So yeah, I think there are those situations.

SENATOR STUTHMAN: Okay, thank you.

SENATOR JENSEN: Any other questions? Thank you for your testimony. Anyone else in a neutral testimony? With that, Senator Howard, do you wish to close?

SENATOR HOWARD: Thank you, Senator Jensen and members of the committee. I think this has been an interesting presentation. I'm always certainly interested in plans that the Department of Health and Human Services projects for the future. I'd like to just share a little information and possibly answer a question that came up. Senator Byars had inquired regarding structure policy, other states where this had been utilized. And as I testified, 22 states have looked at this issue and passed bills or resolutions. It is interesting to note that one of these states that did this was Tennessee. Tennessee was recently, within the last few years, sued by Children's Rights out of New York, which is also a legal firm that is in the process of suing the state of Nebraska on these same issues. And the state of Tennessee did put in a resolution that they would effectively monitor drug use by the state wards that were in their care and custody. I would hate to see this come to a point where we're under a court decision regarding this matter when I think that this body is perfectly capable of addressing this. On a more personal note, when I was working as an adoption worker with Health and Human Services, I noticed an increasing number of children that would transfer over to my caseload who were on behavioral altering medication. And since I've done this a number of years, I started to wonder why was there such an increase? Why was this becoming such a treatment modality? And I think for me it came to a head when I received the case of two little girls who were extraordinarily quiet and docile and willing to oblige whoever was speaking to them at the time. And I looked at this, and I thought these children are just too well behaved. And I get a call from Children's Hospital shortly after that requesting that I come to the hospital because the same foster mother had brought these two little girls and five other grade school-aged children into Children's Hospital requesting helmets due to their out-of-control behaviors. As you can imagine, the hospital and the doctors refused to issue helmets. But at the same time it occurred to me, what are we doing? What is

happening to these children in foster care regarding treatment and medication? So I ask you to take a hard look at this and consider that we do form a treatment committee that looks at the issue. Thank you.

SENATOR JENSEN: Yes, Senator Erdman.

SENATOR ERDMAN: Yes, Mr. Chairman. Senator Howard, as I read through the legislation, it doesn't outline how many members should be on the task force or which...it just says which groups they should come from. Do you have any idea of a number? Did you leave it intentionally open in case there are 300 people that want to be a part? I mean, is there...

SENATOR HOWARD: I really appreciate that you brought that up, very astute of you. And as a matter of fact, when we asked for a fiscal note on this those are the very questions that they asked. They can't provide a fiscal note until there's a number and a length of duration and a number of meetings, and all those important details. What we had envisioned would be a task force of 12 individuals. The task force would meet monthly. And I do have the fiscal note they were able to give me which the statement is, "The cost is unknown since the number of task force members is not defined and the number of meetings is also unknown. The General Fund cost would be very minimal to several thousand dollars depending on the number of members, the area of the state where the appointees reside, that would lend itself to the mileage issue, and the number of meetings the task force held. So those are the decisions to be made. As I said, I would envision possibly 12 people on this task force, certainly no larger. That seems like a number that's actually workable.

SENATOR ERDMAN: Okay. The other question I have, I think just to be clear on the record...you have no knowledge that by passing LB 766 that we would avoid any litigation. That was just...

SENATOR HOWARD: Oh, absolutely not.

SENATOR ERDMAN: ...an example that might have been...

SENATOR HOWARD: From Tennessee as a reference.

SENATOR ERDMAN: Okay.

SENATOR HOWARD: Absolutely.

SENATOR ERDMAN: Just to make sure that...

SENATOR HOWARD: Thank you.

SENATOR ERDMAN: ...the record was clear.

SENATOR JENSEN: Any other questions? I was also going to ask about the fiscal note, so thank you for answering that. With that, no other questions. That will conclude the hearing on LB 766.

SENATOR HOWARD: Thank you.

SENATOR JENSEN: Thank you, Senator Howard. Next we have LB 833. Senator Byars. Also I might mention that Senator Phil Erdman from Bayard, Nebraska, sitting at my far right, has joined the committee, actually quite a while ago. Senator Byars?

LB 833

SENATOR BYARS: Thank you, Senator Jensen, members of the Health and Human Services Committee. I am Dennis Byars representing the 30th Legislative District, "The Caring and Sharing District," (laughter) that's B-y-a-r-s, here to introduce to you LB 833. LB 833 is a fairly simple piece of legislation that actually serves to clarify existing law relative to the practice of medicine and surgery and permits consultation by dually licensed out-of-state physicians via telecommunications technology. It kind of came to me and others by accident. I think that this practice has been going on for a long, long time and no one was aware that the statutes were not clear enough to really allow it in state law. Currently, and I think some of us and many of our friends, many people we know, and I'm certain Senator Johnson in his practice of medicine saw the situation where many people in this state for various reasons looked to doctors in other states for their healthcare needs. In the

situation where many of our communities sit on the borders, in particular, of Kansas, Iowa, South Dakota, Colorado, we might have individuals that travel to outside the borders of those states for their medical consultation and treatment, and others for the reasons that are obvious: may decide to go to the Mayo Clinic in Rochester, Minnesota, might go to M.D. Anderson, can see people going for cancer and oncology treatment to New York and to Texas. Many times, most often doctors who are seeing and treating patients in those given situations need to prescribe follow-up tests when we as a patient come back to Nebraska--very common thing. What we found out was that the existing law was very difficult to interpret as to whether a doctor actually does have the legal right to do that consultation across state lines with the state of Nebraska. So LB 833 is attempting to clarify that confusion. So it's an important piece of legislation but really quite simple. It amends existing statute to allow exceptions to the practice of medicine but does it in a very narrow fashion. The physicians must be graduates of an accredited school or college of medicine with a degree of Doctor of Medicine, they have to be duly licensed in another state to practice medicine, and they have to qualify under one of the narrow exceptions listed in the bill. So with that, I will allow others from the Nebraska Hospital Association and those who are dealing with this issue on a regular basis to follow me with testimony about their experience. I don't anticipate we'll have a great deal of testimony. It's fairly simple is what we would like to do. I think it clearly is a piece of legislation that could go into our cleanup bill and is something that's necessary to get law clarified but it is extremely important also. So with that, Senator Jensen, I will conclude my opening, and will answer questions and will reserve the right to close if need be.

SENATOR JENSEN: Okay. Thank you, Senator Byars. I do have a letter. I don't know if you've received one yet from Health and Human Services system, Dr. Schaefer, who is not taking any position on the bill but did have some comments that, as we move along, you might want to take a look at and see how they might work in your bill (Exhibit 1).

SENATOR BYARS: Appreciate it.

SENATOR JENSEN: Any questions for Senator Byars? Don't see any. May we have the first proponent please?

BARBARA PERSON: (Exhibit 2) Good afternoon. For the record, my name is Barbara Person. I'm a partner at Baird Holm LLP in Omaha, Nebraska, and today I'm here on behalf of the Nebraska Hospital Association. My testimony is in support of LB 833. The Nebraska Hospital Association supports LB 833 with the objective of correcting a statutory imbalance which places Nebraska hospitals in a vulnerable position under Nebraska physician licensure statutes. The hospitals have responsibilities for credentialing healthcare practitioners who practice within their facilities. State regulators suggest that there's also an obligation to confirm licensure of practitioners who don't necessarily practice within the facilities but who may order services and diagnostic tests from the facility. As a result of improvements in technology and communication, Nebraskans are increasingly crossing state lines to obtain medical services and the current statutes make it very difficult for hospitals to determine who must be licensed in Nebraska and who need not. The stakes for Nebraska hospitals are high due to a Nebraska statute which makes it a felony to aid and abet the practice of a profession by an unlicensed individual. And that's the position that they may be in under the circumstances described by Senator Byars. The current statutory definition of the practice of medicine and surgery is overbroad in light of the current trends in medical practice and communication. There are a number of scenarios involving physicians licensed in other states that regularly arise for Nebraska hospitals but which do not create an acceptable risk to public health and safety. The first category is physicians practicing in a bordering state for whom a Nebraska hospital is the closest source of diagnostic or therapeutic services, where either patients or specimens are referred across the border. Typically the physician never enters the state to perform medical services in Nebraska. In some instances, the patient does not enter the state either. Specimens only are sent across the border. In some instances, the out-of-state physician will refer a patient to a Nebraska hospital for surgery by a Nebraska-licensed surgeon. In these cases, the out-of-state physician prepares the history and physical, but as long as this physician's license in the bordering state is in good

standing, it's not an unacceptable risk and Nebraska licensure should not be required. The Nebraska licensed surgeon is in charge of the care provided in the Nebraska hospital. The second category is specialists licensed in other states who have provided services to Nebraska residents in the states in which they are licensed. Commonly the Nebraska resident returns to his or her local community hospital and needs diagnostic tests to be reported to the out-of-state specialist as he or she continues to monitor the patient's condition. Some of these patients also require therapies which could be ordered by a local attending physician but may require review and ongoing monitoring by the out-of-state physician. As a result, it's often more efficient for the out-of-state specialist to order those therapies directly without the involvement of the local physician. Examples would include chemotherapy, home health, and physical therapy. The third category is specialists in other states consulting on the basis of a medical record review who don't necessarily examine the patient. These physicians might never enter Nebraska but their consultation might influence the diagnosis or treatment of the patient and thus come under the auspices of the statute. Such consultations can expand the knowledge base of the local Nebraska physician and thus improve quality of care provided to Nebraska residents. The fourth category is telemedicine practitioners. And telemedicine probably falls into two subcategories of care. The first is an out-of-state physician located outside Nebraska viewing a patient in Nebraska via telemonitor. In this instance, the out-of-state physician is advising the local physician who is present with the patient in Nebraska. The Joint Commission on the Accreditation of Healthcare Organizations has looked at these circumstances and recommended the credentialing of the remote practitioner only if he or she is actually managing the patient's care remotely. It makes sense then to permit telemedicine consultation remotely without requiring a Nebraska license, so long as there is a local physician managing the Nebraska patient's care. The second subcategory under telemedicine is the same factual scenario, except that there is no local physician present with the patient in Nebraska. Any such remote practitioner should be licensed in Nebraska. The fifth category is out-of-state physicians issuing prescriptions in another state without knowing what state the patient intends to fill

the prescription in. Physicians regularly write orders for patients whether prescriptions or orders for services without knowing where that order will be carried out. The Nebraska statute needs to be amended to protect innocent out-of-state physicians from this potential source of liability. LB 833 will allow Nebraska hospitals to honor their institutional credentialing duties by confirming that out-of-state physicians are licensed in good standing in the states from which they are calling or otherwise ordering the services. The amendments will resolve uncertainty among Nebraska hospitals in their credentialing practices. It's time for the physician licensure statutes to be amended in a way that balances the potential risks to patients' safety by physicians not licensed in the state against the benefits to Nebraskans from improved access to those physicians' medical services. LB 833 retains the teeth to require licensure of physicians with a substantial professional contact with Nebraska patients. So Nebraska's hospitals and the Hospital Association urge you to support and advance LB 833.

SENATOR JENSEN: Thank you, Ms. Person. Any questions? Thank you for your testimony. Next testifier in support?

DAVID BUNTAIN: Senator Jensen, members of the committee, my name is David Buntain, B-u-n-t-a-i-n. I am an attorney and a registered lobbyist for the Nebraska Medical Association. And we are here today in support of LB 833. I will try to keep my remarks brief. Last fall we were contacted by the Nebraska Hospital Association as a result of work that had been done by Ms. Person on this issue and had been presented with a copy of the changes which were being proposed. We have circulated this to the...there are a number of specialties that are affected by this in various ways. We are still soliciting comments from them, but so far we have not found anything that gives us heartburn as far as the changes that are being proposed. I do want to give the committee a little bit of background on this because this is an issue that has been a matter of concern to the medical community, certainly in the last ten years and really longer ago than that. And I think it is correct to say that our notions of how patients relate to medical providers and can relate to medical providers has changed because of the mobility of the patient population and also the expansion of the various kinds of technologies that are available. The

issues kind of came to a head in the Legislature in 1997, which was the last time that this section of the statute was addressed. And at that time there was a concern, particularly on the part of radiologists, with a practice where non-Nebraska physicians, non-Nebraska radiologists were beginning to read x-rays for diagnostic purposes affecting Nebraska physicians. And the concern was that you did not have a Nebraska treating physician in the loop necessarily. And if you have your bill in front of you, I can point out what that change was and now what we're changing about that change. At the top of page 3 of LB 833, there's a subsection (7) and that subsection (7) was added by LB 452 in 1997, and that was our intent at that time to balance the kinds of issues that had been discussed earlier today. And I want to note that we are retaining the first part of paragraph (7) which says that the practice of medicine includes "persons who are physically located in another state but who, through the use of any medium, including an electronic medium, perform for compensation any service which constitutes the healing arts that would affect the diagnosis or treatment of an individual located in this state." So the intent of this is to continue to cover, for example, the teleradiology situation and later on there's a specific exception for teleradiology. I do agree that the remainder of the statute which was not addressed by LB 452 includes some language which I would characterize as archaic and doesn't really fit our current circumstances. And what the bill attempts to do, and I think does well, in subsection (7)...well it's really the next section of the act but it appears starting in the middle of page 4...it takes out the current language which exempts out physicians and surgeons in border states under certain circumstances and establishes clearer and I think more modern current criteria as to where you draw the line. I think that's of benefit both to the hospitals and also to the licensure people, and so we are generally supportive of that. There have been some questions raised as to the reference that they have to limit their professional services to an occasional case. The word "occasional" is used in other legal contexts. I wasn't able to find it used in this kind of context. But I think the intent of this, as I understand it, is to try to prevent the situations where it's a physician who has a regular practice of dealing with someone in the state. If we're getting into a regular situation

where they're doing it for compensation, then we think they should be licensed and fall under the law. The other issue that's not addressed here that is an area of concern to physicians...it really goes beyond this bill and is something we will be back in future legislatures, which will affect some of you but not all of you, I realize...is the issue of expert testimony in medical liability cases. There is a lot of activity nationally in the medical liability area because of concerns of out-of-state experts coming into states to testify in cases and, generally, they area outside of the purview of our licensing boards. They're not subject to licensure in this state and a number of states have sought to address that issue in various ways. We decided not to add that issue to this bill but I do want to indicate that that is an area of long-term concern to the medical community. So with that, I'll stop and answer any questions.

SENATOR JENSEN: Thank you, Mr. Buntain. Any questions from the committee? Seeing none, thank you.

DAVID BUNTAIN: Thank you.

SENATOR JENSEN: Any others wishing to testify as a proponent?

DOROTHY ZIMMERMAN: (Exhibit 3) Senator Jensen and members of the Health and Human Services Committee, I am Dorothy Zimmerman, Z-i-m-m-e-r-m-a-n, and I am compliance and regulations officer at Beatrice Community Hospital and Health Center in Beatrice. And on behalf of Beatrice Community Hospital and Health Center and the Nebraska Hospital Association, my testimony is in support of LB 833. During the process of reviewing and revising the Beatrice Community Hospital and Health Center's medical staff bylaws in the spring of 2005, I became aware of a provision in Nebraska law that requires a physician to be licensed in Nebraska for ordering outpatient diagnostic and therapeutic services. My investigation included visiting with various departments including the laboratory, diagnostic imaging, physical and occupational therapy, home health and hospice services. And my conclusion was that occasionally the hospital received orders from physicians in other states who are not necessarily licensed in the state of Nebraska. And

the reason for these were principally the diagnostic tests. There were mainly two situations that I discovered. First were the referrals from Kansas physicians who may not have a Nebraska medical license. Beatrice Community Hospital was the closest hospital for some of these patients to seek diagnostic or therapeutic services. The second area was that referrals were coming from specialty physicians from places like the Mayo Clinic in Rochester, Minnesota. And these orders were generally for follow up or for preparation for a visit back to the specialty physician at the Mayo Clinic. In both of these circumstances, it was becoming very cumbersome for the staff to obtain local physicians' written orders and that it often delayed the diagnostic procedure or the therapeutic procedure, and it was just becoming a very cumbersome process for the staff to obtain local written orders. LB 833 will allow us to confirm that out-of-state physicians are licensed and in good standing in the states where they practice medicine. It will also reduce the number of delays when diagnostic procedures are needed by not having to find a physician licensed in Nebraska to rewrite the order. Beatrice Community Hospital and Health Center and the Nebraska Hospital Association urges you to support and advance LB 833, and I thank you for your consideration in the matter.

SENATOR JENSEN: Thank you, Ms. Zimmerman. Any questions from the committee? Seeing none, we thank you for your testimony. Anyone else wishing to testify as a proponent?

THOMAS SOMMERS: (Exhibit 4) Good afternoon, Senator Jensen, members of the committee. My name, for the record, is Thomas Sommers, S-o-m-m-e-r-s. I am the chief executive officer of Beatrice Community Hospital and Health Center in Beatrice. On behalf of the hospital and the Nebraska Hospital Association, my testimony is in support of LB 833. As a hospital that has a location that is near a border, our facility has found the current legislation problematic for the following reasons: Patients who live in Kansas have primary care physicians who are licensed in Kansas who order diagnostic tests and the patient chooses to have the procedure performed at Beatrice Community Hospital. Under the current legislation, before the procedure could be performed, a physician with a Nebraska license would have to countersign this order. This would require the patient to

be evaluated by another physician and adding cost to the patient. Second, patients who live in our service area but have chosen to see a specialist out of state due to personal choice and necessity, such as the Mayo Clinic, would not be able to have the necessary tests or procedure performed at a Nebraska facility, thus having to have an additional visit and costs and/or travel back to the specialty provider to have the test or procedure done there, thus burdening the patient with loss of time and additional cost. In addition, this would jeopardize the revenue to a facility such as ours if this business was lost. In fiscal year 2004, Beatrice Community Hospital generated over $130,000 charges which resulted in reimbursement to our facility of over $81,000. With a reduction of hospital reimbursement in all areas, this would just add to the burden of shifting cost to other payors. On a personal note, I am a patient who sees a specialist in Kansas City, Missouri, and I would stay with this physician, as I've developed a personal relationship based on trust and results, and I think most patients feel that way. During the past year I've been taking Coumadin, it a blood thinning medication, for arterial fibrillation. This requires periodic testing to ensure the blood does not become too thin or too thick. This is a dangerous medication should the blood become too thin, as any small cut could lead to excessive bleeding. I was having blood work done on a weekly basis to monitor this and also, prior to becoming the CEO in Beatrice, I worked in Arizona under the care of the same specialist in Kansas City. The requirement to see a Nebraska physician to have my blood tested would have been a burden on my time, as I would have had to have taken the time to see another physician. And, in addition, my insurance would have had to have paid an additional expense to have the local physician write the order. If I could have found a local physician who would just write the order without examining me, he or she would have been at a legal risk for prescribing a test without knowing why. This does not just happen to me but it also happens to others, as well as tourists who are also on Coumadin or other medication that require continuous lab tests to monitor their blood levels while they are visiting our state. Passage of LB 833 would eliminate this problem as well as the additional burden it places on our citizens and ensure that the revenue earned from these procedures stay with Nebraska facilities that are performing them.

That is all I have, and thank you for your time and consideration.

SENATOR JENSEN: Thank you very much for your testimony. Any questions from the committee? Yes, Senator Erdman.

SENATOR ERDMAN: Is there anyone attending to the Beatrice hospital today? (Laughter)

THOMAS SOMMERS: Yeah, my chief financial officer.

SENATOR JENSEN: Any other questions? Thank you for your testimony.

THOMAS SOMMERS: Thank you.

SENATOR JENSEN: Anyone else wishing to testify as a proponent? Proponent testimony? Neutral testimony?

DAVID KIPLE: Good afternoon, Senators. My name is David Kiple. I'm a radiologist in the Lincoln community, board certified radiologist, and I've been with the Lincoln community for almost 30 years now. And I'd really like to just...

SENATOR JENSEN: Would you spell your last name for us, please.

DAVID KIPLE: I'm sorry. K-i-p-l-e. I'd really like to just give you a little bit of background from my perspective because I do have a couple of concerns that I hope will be addressed as we proceed forward. I think this legislation is very much needed. I'm a member of Radiology Associates here in Lincoln and we have been pioneers in the Lincoln community in providing telemedicine services, teleradiology services to eastern Nebraska, and we now service about ten hospitals in eastern Nebraska with teleradiology services. This is certainly a very needed consideration. We deal with all of these problems daily, and we have a couple of concerns. We have been asked in the past to provide services to nearby states, to Kansas and to some hospitals close to us. We have not done so because of the regulatory problems and the statutory problems in doing that. I think that as we go forward, we need to hopefully look at a

broader picture in this pattern of changing the statutes. I think that all of the hospitals we go to, or most of them at least, we not only provide teleradiology services but we physically go there. The ability to connect them broadband to us for teleradiology has provided us with the ability to give them near real-time service and interpretation rather than waiting several days but they still require some things on site, and so we do that. If we were to provide services to a nearby hospital in Kansas, for instance, the appropriate statutes indicated here would let me provide those telemedicine services. But if I were to cross the border and try to do that when they need help there, I would still need a state license in that state or I would be committing a felony in practicing medicine. In nursing we have in Nebraska there is I think a more enlightened picture in which at the present time you can actually get a nursing license in Nebraska and you have reciprocity in the nearby 12 or so states. I think that if we look at a broader picture, this would be a very good thing to implement in medicine and would even the playing field. It would prevent me from addressing the law in teleradiology and breaking it if I happen to cross a border. And it certainly would still comply with the intent of what we were doing there. The other, I think, issue that we need to be very aware of is that the issue of providing telemedicine in nearby states is not the same one as providing telemedicine in other countries. And that is becoming a big issue currently in radiology. There are a number of places that do this well but telemedicine services, especially in the middle of the night when there is not enough people, are being sent to India and to a number of foreign countries. In those cases it is much more difficult to determine if the physician, in doing those interpretations, is qualified. In some instances, there are sweatshops where they will have one person apply and get a Nebraska license and that person rubber-stamps everything else that is done. And so I think that we need to be careful. I think the issue (inaudible) the states is a good one. It addresses what we need in Nebraska, what the hospitals need, and what we need. But we need to be careful about getting ourself into situations and applying stricter guidelines to those places where we don't have a good idea of what's actually behind the scenes. That's really all I have. Thank you.

SENATOR JENSEN: Thank you. Any questions? Thank you for your testimony. Anyone else in a neutral testimony? Senator Byars, do you wish to close?

SENATOR BYARS: Senator Jensen, members of the Health and Human Services Committee, I would close briefly. We certainly had not seen any of the suggestions as far as technical language on the part of Health and Human Services until we presented the bill today, so we will...it's a shock, I know. (Laughter) But we will work with Health and Human Services to look at those issues. This person who has worked in advising the Hospital Association (inaudible) will have a copy of this and we'll address those issues. And I think they're fairly minor but we can take care of them. I want to thank you very much.

SENATOR JENSEN: Thank you. That will close the hearing on LB 833. Senator Cunningham, do you wish to begin on LB 838?

LB 838

SENATOR CUNNINGHAM: Well, good afternoon, Senator Jensen and members of the Health and Human Services Committee. I'm Doug Cunningham, C-u-n-n-i-n-g-h-a-m, State Senator representing the 40th Legislative District. I'm here today to introduce LB 838 which would allow certified registered nurse anesthetists to utilize fluoroscopy to locate the precise point to inject pain medication among other procedures. A certified registered nurse anesthetist, or a CRNA, is a licensed registered nurse holding the certificate as a nurse practitioner in the practice of anesthesia. There is some history behind the introduction of this legislation. A year ago, Avera St. Anthony's Hospital in O'Neill and North Central Anesthesia Services, LLC, submitted a petition for a declaratory ruling to the Nebraska Department of Health and Human Services. The petition requested a determination on the question, under Section 180 NAC 16 "and following consultation, collaboration, and with the order of the physician, may a CRNA request that fluoroscopic services be provided by a medical radiographer for the purpose of having the CRNA locate the precise point where pain medications will be

injected." Dr. Richard Raymond, the director of Regulation and Licensure for HHS at that time, determined that the Radiation Control Act entitled 180 NAC 16 prohibited a medical radiographer from performing fluoroscopy services for the purpose of locating, for a nurse anesthetist, the precise point where pain medications will be injected. However in his order, Dr. Raymond acknowledged that the use of fluoroscopy to help determine the precise location to inject pain medications appeared to be very beneficial. He also noted that it can currently be performed if performed by an individual listed in Section 71-3508, subsection (3). He suggested that the petitioners may want to consider asking the Legislature to amend the statutes to allow performance of the procedure proposed and to address the role of mid level practitioners and the utilization of x-ray systems. LB 838 adds certified registered nurse anesthetists to the list of persons exempt from the rules and regulations in Section 71-3508, subsection (3) regarding qualifications for the use of x-ray radiation-generating equipment operated for diagnostic purposes, thus carrying out the changes suggested by Dr. Raymond. As I understand, today a physician from the O'Neill hospital, as well as a CRNA from North Central Anesthesia Services, LLC are here today to testify in support of the bill. If there are any questions, I can try to answer them, however I believe the following testifiers are much more versed in this than I and they would be happy to answer your questions.

SENATOR JENSEN: Thank you, Senator Cunningham. I think your explanation was longer than the bill. (Laughter) But that's okay. Any questions of Senator Cunningham?

SENATOR ERDMAN: Sometimes it just has to be, right?

SENATOR CUNNINGHAM: Has to be done.

SENATOR JENSEN: Yeah. Thank you. May we have the first proponent, please? And may I see a show of hands of anyone else who wishes to testify on this bill? I see...oh, okay. Thank you.

RON JENSEN: Chairman Jensen, and members of the Committee on Health and Human Services, my name is Ron Jensen. I'm a registered lobbyist appearing before you this afternoon on

behalf of the Nebraska Association of Nurse Anesthetists and in support of LB 838. Senator Cunningham covered the history of the bill, and I'm not going to talk about the content either because there are folks here who are much better prepared than I. But it is just a little quirky in that it amends a state law which exempts certain practitioners from regulation. And we approach it this way because in the petition that Senator Cunningham referred to last February, Dr. Raymond's order or response to the petition contained the statement "the use of fluoroscopy to help determine the precise location to inject pain medications appears to be very beneficial. It can currently be performed if performed by an individual listed in 71-3508(3)", and I'll read a list of those, it's not that long. Petitioners may want to consider asking the Legislature to amend the statutes to allow performance of the procedure proposed and to address the role of mid-level practitioners and the utilization of x-ray systems. Those practitioners or health professionals who are presently exempted from the regulation and thereby are authorized to do this are podiatrists, chiropractors, dentists, physicians and surgeons, osteopathic physicians, and physicians assistants and veterinarians. And our bill would add certified registered nurse anesthetists to that list. It would allow them to utilize the display of fluoroscopic equipment and perhaps I should explain, and I know Dr. Johnson will check me on this, if you're not familiar, fluoroscopy is real-time x-ray. It's an x-ray or radiograph that's a picture, a still, and fluoroscopy, I think it's fair to say, is a moving picture or x-ray television. Is that? Good. Close enough. And by watching that, a CRNA can, in this example, insert a needle and see exactly where that line is going and if it's going into the joint. The equipment is operated by a medical radiographer or an x-ray technologist. Now in discussion it's been argued that the bill would allow CRNAs to also operate the equipment and that's not the intent at all. The intent is to be able to use that display to place a line. And all of that, I think it's important to emphasize, is carried out pursuant to a physician's order. A physician orders this procedure and orders it to occur. The only other thing I wanted to say to you is that we met with Dr. Raymond after he issued the order and we had a very good meeting with him. And he said again to us...he didn't say, you guys go to the

Legislature, but he did say you need to address this to the Legislature. You seem to have a legitimate issue here. I subsequently called him in the spring of last year and asked him, we were at the point of preparing legislation, does this in your mind require a 407 review? And his statement to me was that I don't believe it rises to that level of requiring a 407 review. Now I was told a little earlier this afternoon that Dr. Raymond is having a little trouble recalling that conversation. If Dick Raymond says he's having trouble recalling, I believe it. I would hope the committee would also believe that I wouldn't make it up. The only other thing I want to say about this is that there is another bill that is being heard conjointly with LB 838 that authorizes advanced practice nurses to do the same procedure. I want to note that that bill was developed independent and introduced independently of this one, and that the Nebraska Association of Nurse Anesthetists is not at this time taking a position on it. If you have questions, I would attempt to answer them but I think the people who will come after me will probably be more illuminating.

SENATOR JENSEN: Any questions of Mr. Jensen?

RON JENSEN: If I could, Mr. Chairman, I'd like to be followed by Wendell Spencer who is a CRNA from O'Neill.

SENATOR JENSEN: Okay. All right. Thank you. Wendell?

WENDELL SPENCER: (Exhibit 1) Thank you, Senator Jensen, and members of the committee. Thank you for allowing me to testify on this important bill that we see as an access to care issue in rural Nebraska. My name is Wendell Spencer. That's spelled, W-e-n-d-e-l-l S-p-e-n-c-e-r. I'm a certified registered nurse anesthetist with a master's degree who has been in practice in Nebraska for most of my career of 19 years. I've practiced in most of the hospitals west of Grand Island and north of that location, and currently practice for the last 13 years in O'Neill, Nebraska. Our group covers 12 to 13 different hospitals, depending on the time of the year and need, in north central Nebraska and southern South Dakota. And our hospitals are not unlike the other hospitals in rural Nebraska who, I believe the number is 85 of those hospitals depend solely on

the resources of the certified registered nurse anesthetist to provide services. I have served as the state president of the Nebraska Association of Nurse Anesthetists. I serve currently on the advisory council to the Bryan school of nurse anesthetists. I have served on many committees in both Nebraska state and national office, and the most recent being a committee member on the practice committee of the American Association of Nurse Anesthetists. I also just finished up a term as the Region IV director of the Nebraska Association of Nurse Anesthetists which covers all of the midwestern states, ten in all. As technology has changed, so have the needs of practitioners in the areas of anesthesia. In Nebraska's past, shoe salesmen used to utilize radiologic images to size the patient's foot for the best shoe size. Much has changed since then in the use of radiologic techniques, both in the lack of its use to sell shoes now and also in the need for advanced technology to help nurse anesthetists provide access of care to our patients. Since the first nurse anesthetist practiced in Wakefield, Nebraska, in 1982, certified registered nurse anesthetists have had a rich history of quality, effective, safe care to our patients in all anesthesia settings. This bill is about being able to utilize the tools and technology now available to provide better access for patient care in the most effective way possible. Nurse anesthetists train in rigorous training programs all over the United States to learn the art and science of nurse anesthesia. These programs teach nurse anesthetists to evaluate radiographic images to assess central line placement, endotracheal tube or breathing tube placement, and perform other functioning utilizing radiographic images. Advanced coursework in pain management is done side by side with our physician colleagues in courses such as AAPM courses, SPPM courses that allow practitioners to use real time fluoroscopy techniques which are also used on cadavers for that specific training. My partner Larry Finley and I have spent the better part of six individual sessions at these meetings in order to learn these techniques who are taught by some of the world's greatest people in pain management services including Gapora Rax (phonetic). These courses teach one to four hours of radiation safety techniques which are reinforced by the use of medical radiographers, in our case, which run the fluoroscopy machines who are well versed in these techniques. Real-time evaluation of the participants

in these courses are done by internationally recognized as pain management experts. And they feel and we feel, also, that our supportive physicians, PA's, and nurse practitioners...and you're about to hear a list of the supportive physicians, PA's, and nurse practitioners, and Dr. Fitch will bring you in his testimony, feel very strongly that fluoroscopy allows us to more effectively treat the patient by seeing the precise needle placement area. A partial listing of states that allow the use of fluoroscopy by nurse anesthetists, and this is just a partial listing, include all of the states that surround Nebraska. Interestingly, South Dakota, North Dakota, Iowa, Illinois, Indiana, Montana, New Hampshire, Kansas, California, Washington, Wyoming, Texas, Arizona, and New Mexico, Mississippi, Louisiana, Michigan, Arkansas, and Colorado is just a partial list of those states that do allow this. In providing quality care to our patients, this technology is a tool to make certain that these procedures are done in a safe and effective fashion close to home. As Dr. Fitch will discuss, credentialing is done locally at the hospital in assessing the competency of each physician and the competency of practitioners including nurse anesthetists. As our state statute states, certified registered nurse anesthetists work in consultation, collaboration, and with the consent of the physician. We get referrals from neurosurgeons, spine surgeons, family practice physicians, and other physicians throughout the state that recognize that we provide for quality of care. There is nothing that changes in the relationship that we have done in the past. Nurse anesthetists will continue to provide quality access to anesthesia care in all areas of Nebraska, both rural and urban. I would ask for your support of this bill to best utilize the technology available to our patients in Nebraska, and I certainly appreciate your time and attention. Thank you very much.

SENATOR JENSEN: Thank you very much. Any questions?

WENDELL SPENCER: Senator Jensen...

SENATOR JENSEN: Yes.

WENDELL SPENCER: ...there's a letter of support that just came to my attention. Could I ask that that be entered into

the record, please, sir?

SENATOR JENSEN: We'll do that. But Dr. Johnson had a question.

WENDELL SPENCER: Yes, sir.

SENATOR JOHNSON: What would you suggest would be the level of training? You know, you went through quite a list of all the training that you had taken. Do you have any comment or suggestions as to how much training and so on would be appropriate before, you know, they form a team like you?

WENDELL SPENCER: Okay. That's a very good question, Senator Johnson, and I think it's one that warrants very careful consideration. Before we got privileges to perform these procedures in O'Neill, Nebraska, we went before the credentialing body of the hospital that's made up of our physicians and medical staff in order to show them that the continuing competencies and advanced education in these particular areas have been met. I still think that's the best way to credential people is at the local facilities for two reasons: number one, the local physicians and providers in that area know their practitioners the best and they can identify their competencies and skills; and number two, they can keep an eye on their progress. And in our particular situation, we give QA data back to the medical staff every quarter so they get to watch our outcome studies which are, by the way, evaluated by nursing staff so that we don't doctor the books, so to speak. So I think...am I answering your question in a roundabout way a little bit?

SENATOR JOHNSON: Well, yeah. Yes and no. And I guess what I'm getting at is you really gave quite an impressive list of how you went about it before you started doing the procedures and so on, so that you could as best possible demonstrate to your local hospital, yes, this is safe and effective for us to be doing this. Can you expand a little bit more on the training and so on that you would think other hospitals might want to look for should this bill be advanced?

WENDELL SPENCER: Sure. I think it's important to note that the statute, the Radiation Control Act, doesn't provide for

those types of continuing education requirements for any of the exempted providers in that statute. However, I think that hospital groups are very careful about their credentialing committees in order to make sure that the provider is very competent in those areas before they move forward. And we as an association speaking as a state association, the Nebraska Association of Nurse Anesthetists, have really encouraged our members that if they take this role on that they need to make sure that they're competent, safe, and well-skilled at these procedures because, obviously, they will be very carefully looked at.

SENATOR JENSEN: Any other questions?

WENDELL SPENCER: Thank you.

SENATOR JENSEN: Thank you for your testimony. Next testifier in support please?

RICHARD FITCH: (Exhibit 7) Thank you, Senator Jensen.

SENATOR JENSEN: Yes.

RICHARD FITCH: My name is Richard Fitch, F-i-t-c-h. I'm board certified in family medicine. I've been in the private practice in a healthcare provider shortage area for 35 years; therefore, I think I understand unique needs of rural care. I have written authorization from 28 physicians to testify in favor of this bill. They are: Dr. Barbara Gutshall, Dr. Jay Allison, Dr. Matt Winkelbauer, Dr. Anthony Akainda, Dr. Ron Cheney, Dr. Dennis McGowan, Dr. Morse, Dr. Brandon Essink, Dr. Doug Dilly, Dr. Roger Rudloff, Dr. Troy Dawson, Dr. D. Sammons, Dr. Bell, Dr. Nyunt, Dr. Wu, Dr. Mel Campbell, Dr. Dean Gilg, Dr. Sonya Hansen, Dr. Ray Carlson, Dr. Bruce Forney, Dr. David Isom, Dr. Jamie Dodge, Dr. Glen Forney, Dr. Rommie Hughes, Dr. Harold Keenen, Dr. Jeff Lias, and Dr. Tim Watt. Therefore, I find it hard to understand why the Nebraska Medical Association is opposing this bill when they do not speak for us rural physicians. This is not a scope of practice issue. Certified registered nurse anesthetists have been credentialed by hospital boards, their privileges are based on their competence, they've been providing quality care for the relief of pain for over 20 years, and I

personally witnessed the excellent outcomes. Rural physicians' times are already stretched to the limit. If we continue to require that a physician be physically present when a CRNA sees the need for a fluoroscopically guided procedure, we will continue to see a limit to access of care and that's the bottom line that touches my heart. These are my patients and anything that stands in the way of them getting care makes me bristle and cry when I hear other people telling me what my patients need and what kind of care they need. I believe the passage of LB 838 will provide safer and more effective care for rural areas. Thank you so much.

SENATOR JENSEN: Thank you. Could you just explain for a novice, when you do this and you use this procedure, other than for orthopedic is it used any other place? I can certainly understand what you're doing on epidurals and some of those issues and to anesthetize anyone on any part of their body. But is it used other than for that purpose?

RICHARD FITCH: Well, this is being used for the control of pain.

SENATOR JENSEN: For the control of pain...

RICHARD FITCH: Yes.

SENATOR JENSEN: ...for anything then?

RICHARD FITCH: For neuropathic pain, for nerve root pain, transforaminal nerve blocks are being done, epidural steroid injections. They are safer and more efficient and done better with the guide of fluoroscopy. The way the law states now that a physician or a podiatrist or a veterinarian has to be present for them to do that. And that's what I'm arguing against.

SENATOR JENSEN: Sure. I understand. Any other questions? Thank you.

RICHARD FITCH: Thank you.

SENATOR JENSEN: Anyone else wish to testify in support?

ROGER KEETLE: (Exhibit 1) Good afternoon. For the record, my name is Roger Keetle, K-e-e-t-l-e. I'm a registered lobbyist for the Nebraska Hospital Association and, for the record, the Nebraska Hospital Association's 85 members and the 35,000 people we employ is in position to support LB 838. Again, as has been testified, based upon the review of the qualifications and training of certified registered nurse anesthetists, and the recommendations of the hospitals' medical staff, the boards of trustees at several of our member hospitals have authorized certified registered anesthetists to perform radiologic procedures in the hospital. The supervision of a physician or a physician assistant to supervise someone running the fluoroscopy machine is found to have been unnecessary. Again, we support the ability of the certified anesthetists to bring this needed services to Nebraska. With that, I would answer any questions.

SENATOR JENSEN: Thank you, Roger. Any questions from the committee? Yes, Senator Cunningham.

SENATOR CUNNINGHAM: I'll bring you the apple tomorrow, Roger.

ROGER KEETLE: (Laughs) Okay, thank you.

SENATOR JENSEN: Thank you. Next testifier in support? Anyone else wish to testify in support? In opposition? If anyone else is going to testify, would you come up to the first row, please, so we can do a smooth and quick transition? Thank you. Welcome.

JOHN MASSEY: (Exhibit 2) Good afternoon. My name is John Massey, M-a-s-s-e-y. Thank you for the opportunity to testify before you today. I'm a physician who specializes in interventional pain medicine, a full-time practice with pain medicine here in Lincoln. I'm board certified by the American Board of Pain Medicine and also previously board certified, as well, by the American Board of Anesthesiology. The issue before us today regarding LB 838 essentially boils down to how to provide the best possible treatment of pain for the patients and the citizens of our state. These legislative proposals attempt to increase the scope of practice of nurse anesthetists, as well as nurse

practitioners, in the treatment of pain conditions. Chronic pain is one of the most expensive disease processes to our economy, as well as to individuals. Back pain alone accounts for an estimated $25 billion annually in direct medical costs as well as disability. It is the second most common reason patients seek medical care and the single leading cause of disability annually in the United States. Chronic pain is expensive because it leaves previously productive individuals, healthy individuals, to lose their jobs, employability, destroy their families, and cause extreme expense to society. The cost of back pain alone in many estimates exceeds the cost of cancer care and cardiac care combined. As pervasive and costly as pain is, it's also a subjective disease process. It's challenging to define and treat. Pain is more difficult to study than many ailments, and the effectiveness of treatment is potentially more difficult to measure. In the past, treatment approaches lacked sufficient medical evidence to support or refute a particular course of action. This is no longer the case. An ever-growing body of medical literature is developing that supports advancing treatments, refuting older and more established practices. We're here today because some mid-level providers and physicians who do not practice pain medicine full time have failed to keep abreast of these changes and the potentially great benefit which could be provided to their patients. Unfortunately, some mid-level providers have used this incomplete understanding of best practice models to provide services which are ineffective, not indicated, and thus costly to both patients and those paying for these services. Blind spinal injections, in many instances, have been clearly demonstrated to provide little or no benefit to patients resulting in increasing costs, as well as reducing utilization of more effective treatments. Targeted injections, that is those injections using some sort of radiographic imaging guidance, that is fluoroscopy, CT scan, et cetera, have been shown over the past 12 to 15 years to be far more effective at both diagnosing as well as treating these pain conditions. However, fluoroscopy is merely a tool used by trained physicians in making an appropriate diagnosis of the specific cause of the pain. We refer to this as the pain generator. In many instances, and importantly, these fluoroscopically targeted injections are the only way of making appropriate diagnosis for the

patient. The importance of this is that that accurate diagnosis then drives treatment decisions that are aimed at providing the best chance of preventing the pain from becoming chronically debilitating and thus far more expensive. So this is how we determine what type of procedure is next used in order to be more likely to improve the patient. A comparison of what we're talking about here today that may make some illumination for you is a situation of interventional cardiology. I believe no one here would consider allowing nurses to perform cardiac catheterizations to diagnose under fluoroscopy the nature of heart disease. Cardiologists receive extensive training to utilize fluoroscopy to perform these procedures to diagnose and treat heart disease. This saves lives and reduces costs to society. Pain physicians similarly receive extensive extra training to utilize fluoroscopy and treatment, minimizing discomfort and cost to society. The subjective nature of pain serves to muddy the waters though as it is difficult for laypersons to understand that inappropriately performed or improperly supervised treatments for these patients can seriously impair results for the patients. Rather than providing relief, such treatments may lead to chronic and debilitating conditions. Several years ago, as the literature described the necessity of these diagnostic procedures to improve outcomes, physicians practicing pain medicine were required to receive extensive training beyond their residency requirements. This training specifically focused on the appropriate utilization of fluoroscopic techniques to increase safety and efficacy. Advanced training is necessary because the consequences of even slight misplacement of these medications can result in permanent paralysis, stroke from medication being delivered into the blood vessels of the spinal cord or the brain or both. The training is not available to or appropriate for nurses. I'm not stating this just as a professional opinion. The International Spinal Injection Society, ISIS, and the American Society of Interventional Pain Physicians and other organizations carefully and exclusively warn of these risks. These organizations were formed in part due to an alarming increase in deaths and permanent injuries which occurred over the last decade from these procedures being performed by less well-trained physicians. I am not aware of any other place in the world which would consider allowing nonphysicians to perform these procedures. The

effect of LB 838 and LB 908 would be to seriously erode patient outcomes for pain patients, as well as to expose the citizens of our state to risks from improperly performed and ineffective treatments. In the interest of time, I'm not going to go further here, except I did include in your packets a photograph of an actual radiographic imaging. And I think maybe in this instance, you did ask the question of what are these indicated for? What do we do here? This might help you to clarify what's going on. What we have on this last page is a picture with two images: one an AP view and one a lateral view of a procedure which would commonly be performed to perform a diagnostic injection. That is a facet injection. Facet joints are one of the things that are responsible for back pain. If you see in my picture here on the top you can see a needle which goes and clearly delineates a facet joint, which is that oval looking structure. Just to the right of that is a dark blob of material. With that imagine alone we would not be able to determine if this injection was going to lead to an embolus because that blob of my injection material sits right over a radicular artery or a vein structure. And if that injection material goes into the vein, it's only about 8 millimeters away from the brain vessels itself. Therefore, if I would use that injection and that image alone to inject this medication, I could either, one, relieve the patient's suffering if they are having a facet-mediated pain or, two, lead to death on the table. This is not some information that's available to primary care physicians. This is not information that's available to nurse anesthetists. There is a fourfold increase in deaths from these procedures being performed over the last decade...deaths and permanent paralysis. This is an issue that needs to be further addressed before we can assume that this would be a safe endeavor for the citizens of the state.

SENATOR JENSEN: Thank you, Doctor. Any questions? By the way, we were going to have two hearings together. We thought that would work, and then kind of decided not, think it would be better if we held them separately. However, would your testimony be the same for the next bill? And I guess, if that is the case we can, through our recordings, allow that to happen.

JOHN MASSEY: I have also served for 11 years on the faculty

of the Bryan School of Nurse Anesthesia. And I can state, as a member of that faculty, that at no time, in any of those instances, have any of these procedures been taught by the faculty or the school. When it comes to advanced practice registered nurses, I am not aware of any training or any possible reason why that would be possible. I think it is maybe perhaps a sign of how easy it would be for less and less oversight to lead to increased morbidity for patients and the citizens.

SENATOR JENSEN: I see. Any other questions from the committee? Senator Byars.

SENATOR BYARS: Thank you, Senator Jensen. I would appreciate it, Dr. Massey, if you could share with us the information that you have quoted relative to the morbidity, the increase in deaths and injuries...

JOHN MASSEY: Yeah.

SENATOR BYARS: ...over the last decade. If you could share that information with us...

JOHN MASSEY: Absolutely...

SENATOR BYARS: ...and where they were attributed...

JOHN MASSEY: Well...

SENATOR BYARS: ...to whom and ...

JOHN MASSEY: Absolutely. A lot of the time...it seems when we're asking questions about this, people who don't understand the technical aspects of this procedure tend to talk about, well, with fluoroscopy we can see if the injection is going into the right place and what have you. And really what's driven this over the last decade, is computer technology because the fluoroscopy has gotten better and better at allowing a resolution that's finer and finer so that we can see, when we're doing this procedure under live review, it's like a movie; not like a photograph that you have in front of you. We can see where that contrast solution, that medicine that delineates where the medicine's going, we can see where that's going. When you

have a catastrophic event, what you see is medicine going into a blood vessel. These areas...one of the testimonies said that these are safer injections. They're absolutely not safer. They're more risky because we are going closer to the blood vessels which supply the blood supply to the spinal cord, as well as to the brain. And if you don't know exactly how to avoid that blood vessel, and you don't carefully document that, that would be something that would be beyond the purview of just an anesthesiologist who had not trained in pain medicine, certainly beyond the purview of a primary care physician who was watching this procedure and also beyond the purview of an anesthetist or a nurse doing this...if you don't note that the medicine isn't going into the blood vessel, these medications are particulate in nature. So it's just like a thrombus and that's what leads to strokes. So they lead to brain stem strokes, they lead to death of the spinal cord below the level of the injection. And that is not something treatable once it occurs, and it's immediate.

SENATOR BYARS: I appreciate that very much but I would appreciate you sharing that where the information comes from, the publications...

JOHN MASSEY: Oh, the...

SENATOR BYARS: ...empirical evidence, if you will.

JOHN MASSEY: ...the evidence actually...

SENATOR BYARS: We're quoted a lot on this type of thing without any empirical evidence to support it.

JOHN MASSEY: Uh-huh. The best literature on that is the International Spinal Injection Society. The author who has most looked at this is Nikolai Bogduk. And he is an anatomist from Australia who basically first held our feet to the fire in terms of showing us that the treatments that we've been doing in the past weren't effective, and that there were more effective treatments. He got everybody interested in doing these fluoroscopically guided procedures, and then he found out that the mortality and the morbidity from poorly trained people skyrocketed. So he also published that data.

SENATOR BYARS: If you would share it with us, we'd appreciate it.

JOHN MASSEY: Yes, sir.

SENATOR BYARS: Thank you.

SENATOR JENSEN: Yes, Senator Cunningham.

SENATOR CUNNINGHAM: Senator Jensen, for clarification, am I allowed to ask questions as the...

SENATOR JENSEN: Sure.

SENATOR CUNNINGHAM ...introducer of the bill?

SENATOR JENSEN: Go ahead.

SENATOR CUNNINGHAM: I maybe misunderstood but did you say that, Dr. Massey, that even as we do it now, that a regular physician in the room would not even be qualified to oversee this?

JOHN MASSEY: Yeah. I think...

SENATOR CUNNINGHAM: That you did say that?

JOHN MASSEY: I think that that's a dangerous situation. I can't say whether that's qualified. The analogy is very much similar to a primary care physician ordering a heart catheterization. You know right now nurses have the privileges to place an IV catheter into a central vein. They could put medication in there. It's who's reading that data in order for that to be safe.

SENATOR CUNNINGHAM: Okay. The other question I would have then for you when you're making that statement and you were also talking about the large increase in the last years of serious injuries and even deaths. But yet Dr. Fitch, when he testified, he had an impressive list of doctors...and I recognized some of the names of those doctors as rural doctors. Why would those doctors, if it was really this dangerous, why would they be willing to put their name on

the line for this?

JOHN MASSEY: I think if they knew the risks involved and they were fully informed of that literature that is out there that they would rescind that. I can't believe that anyone would support this kind of a treatment recognizing the increased morbidity and mortality that's out there. What it is is that even...it's like a lot of other things in medicine. They can be relatively rare. You know, we're playing Russian roulette and there hasn't yet been a bullet in the chamber of any of their patients. That doesn't make it a good practice. It certainly doesn't make it good policy.

SENATOR CUNNINGHAM: I guess I'm not a doctor, obviously, but I don't know that I tend to agree with all of your statements.

SENATOR JENSEN: Any other questions? Thank you, Dr. Massey, for coming forward. Next testifier in opposition please?

DAVID KIPLE: My name is David Kiple, K-i-p-l-e. I'm testifying in opposition to LB 908 and LB 838, so you can use my testimony for both those if you wish. I am a board certified radiologist. I'm a member of the International Spinal Injection Society, and I do perform these procedures. The use of medical radiation devices is extremely important in modern medicine and, as many people have said, they do allow us to be more precise in what they do but they also carry more dangers with them. And also they carry an obligation with them to use those wisely by people who are appropriately trained. The operators, the patients, and the healthcare workers involved all are at risk with the use of these devices, and untrained personnel can cause harm in many ways, not only to the patients but to those who they work with. As a radiologist, I received training in radiation protection, radiation physics, radiation damage to the human body, and I've done this over several years of residency. I would tell you that it's not very easy to obtain this information after a couple weeks of courses. It is also not easy to obtain the ability to look at 3-D anatomy in a few easy four-hour courses. These topics are not addressed in regular medical school training. They are

usually at the purview of residency training. To exempt people from the knowledge of how these devices work, the harm they can produce, and the training they need to limit radiation doses is not good public health policy. Devices such as C-arm fluoroscopy in use by untrained personnel are particularly dangerous. And I would tell you that there's sort of been an issue here of saying that this is a natural progression from using x-rays to C-arm fluoroscopy. The use of C-arm fluoroscopy is a major leap from looking at x-rays. It is a major leap in the presentation of the anatomy and the training needed to view that, and it's a major leap in the exposure of radiation involved. There is not much public health risk from exempting someone from using an x-ray machine in their office. There is a significant public health risk in exempting people using C-arm fluoroscopies. And I would challenge some of these people to tell you what the actual output of a C-arm fluoroscope is because it's much, much higher than an ordinary x-ray machine. It carries significant scatter radiation, which is usually collimated out by ordinary x-ray machines and thus radiation to the personnel and to the operator and the patient is much higher. To exempt them from strict controls in recordkeeping and radiation monitoring is a setup for a disaster years later in the making. The radiation protection (inaudible) is directly related to the operator's experience and to the training he has and the use of it. The ability to use very short fluoroscopy times comes from proficiency in both recognizing anatomy and recognizing the best way to approach the patient in using these devices, which can be rotated around the patient in many angles. These devices produce small 3-D pictures about this large which you have to look at. And you look at multiple projections, and from that the operator must assimilate a 3-D picture of the anatomy. And this is not something that comes from a few hours of training. It comes from years of looking at the anatomy, being experienced in it, and it varies considerably with the variation of patient body habitus and the size of the patient from which you are seeing. It's necessary to quickly identify where you are, the anatomy you are, and limit the amount of exposure in order to keep the patient safe. These devices literally can deliver therapeutic radiation doses if they are used inappropriately. We are literally talking about placing a needle in a 2- or 3-millimeter space within the

transforaminal injections. And the ability to do this, again, is very dependent on training. If you don't do it, you are going to get into trouble and you are going to have injections that go in the wrong place with potentially, and documented, serious complications. The fluoroscopic injections, particularly corticosteroid medicines for pain control, long-term pain control, are most problematic in this relationship, and they have caused cases of permanent paralysis, which mostly the people involved in the spinal injection societies, the board certified specialists, are in the loop in the literature that is coming out in addressing this. These organizations and the people involved with them outline strict protocols for the performance of the procedures, for the training involved, and for the adequacy of the equipment. To allow people who are not adequately trained in the recognition of 3-D anatomy, radiation protection, and harmful effects of radiation, to be exempt from these qualifications is not only dangerous from a public health standpoint, it is very poor public policy. I would let you have questions.

SENATOR JENSEN: Thank you. Any...Senator Cunningham?

SENATOR CUNNINGHAM: Yes, Doctor, for clarification, are you reading the bill to mean that the CRNA would actually operate the machine?

DAVID KIPLE: No. And I think that's a point we ought to address also.

SENATOR CUNNINGHAM: But didn't you state in your testimony...it sounded like they were operating the machine.

DAVID KIPLE: It is very important for the operator to place the machine appropriately to limit the radiation protection. The radiation technologist does not normally do that. And I work with these people all the time. They can bring the machine in the room and turn it on and get the image for you but it's up to you to get the angles you want, to place the machine appropriately to try to limit the doses, limit the scattering that goes back to the radiation people. A technologist does not do that for you. So it's a moot point to say who actually turns the machine on. In the end, it is the operator who controls the angles, the scatter, the

radiation of the machine and, most importantly, how long the machine is on.

SENATOR CUNNINGHAM: But the CRNA is not the one running the machine.

DAVID KIPLE: Yes, he is. He's the one with the foot pedal.

SENATOR CUNNINGHAM: I don't believe...that's not the intent of the bill anyway.

DAVID KIPLE: The operator...

SENATOR CUNNINGHAM: That question did come up right before we came down here but the intent of the bill is not for the CRNA to operate the machine.

DAVID KIPLE: The operator is very much in control. Now he either has to say, step on that pedal, to the technologist and then take off, which is inefficient, or he has to do it himself. And that is the primary way to limit radiation exposure. So, yes, it all comes back to the person in charge and the operator. That's absolutely true.

SENATOR CUNNINGHAM: Thank you.

SENATOR JENSEN: Senator Johnson.

SENATOR JOHNSON: I'm just curious. I've forgotten. How long a period with a fluoroscopy machine on the spinal cord would it take before you got some injury, and I realize the injury might be down the line a ways but...

DAVID KIPLE: Each machine is calibrated differently. The exposures are significantly high, they can put up to 9R a minute out of some of these machines. And because they don't have collimators, you get a tremendous amount of skin exposure and (inaudible) skin scatter. You also get that because the machines are a closed loop and you can't get a long distance film, which takes away some of the low energy beams. So it's dependent on the answer; it's depending on the particular machine. They need to be well calibrated, they need to be monitored by the person using them to know that they're still in calibration. And the person using

them needs to know how much that particular machine's putting out so they have some idea of what kind of radiation they're giving.

SENATOR JENSEN: And you did say that we could use your testimony for the next bill?

DAVID KIPLE: Yes. Please.

SENATOR JENSEN: All right. Thank you very much. Next testifier in opposition, please?

PHIL ESSAY: (Exhibit 3) Good afternoon. My name is Phil Essay, spelled E-s-s-a-y. I'm a physician who is board certified by both the American Board of Anesthesiology and the American Board of Pain Medicine. I have been in private practice as an anesthesiologist for eight years in Lincoln, and as a full-time interventional pain physician in this city for the past three years. I believe that on the surface it might appear that opposition to LB 838 represents another chapter in what I think is an age-old effort on the part of some physician anesthesiologists to limit the scope of practice of their certified registered nurse anesthetist counterparts. I assure you that this is not the case. This is more an issue of expansion of scope of practice. The current radiation use qualifications of the state of Nebraska in no way compromise or even limit a certified registered nurse anesthetist from performing his or her duties of providing safe, general, and/or regional anesthesia. In fact, the lowering of the radiation use standards of the state of Nebraska allowed by this bill provides no medical advantage in the practice of anesthesiology to anyone, in particular the patients in this state. The real motivation behind this bill, however, is to provide an avenue for CRNAs to perform highly specialized procedures known as spinal intervention or spinal injection. I think this is an important part that's been overlooked in some of the testimony thus far. We're talking about two separate issues. We're talking about the practice of anesthesia, and we're talking about the practice of pain medicine. All anesthesia providers, anesthesiologists and nurse anesthetists alike, are qualified to perform spinal blocks and epidural injections. In the perioperative setting, these procedures are routinely performed very

safely without the use of radiation or fluoroscopic guidance and have been for years. The current pain medicine literature though dictates that the spinal interventional procedures for the treatment and/or diagnosis of pain do require fluoroscopic guidance. The diagnosis and treatment of pain and painful conditions is really no different than the diagnosis and treatment of heart disease or cancer. It's the practice of medicine and it's outside the scope of the practice of a registered nurse. While the justification for this bill is to expand the availability of services to the citizens of this state, the consequences of exempting CRNAs from current radiation safety requirements would be to significantly and, in my opinion, inappropriately expand the scope of practice of these individuals. LB 838 would allow them to practice medicine as an interventional pain specialist or interventional radiologist, therefore compromising the medical care of these patients and the treatment of chronic pain in this state. Just as a side note to clarify a point about who is running the C-arm, the fact of the matter is is that in order to do these procedures appropriately, you have to be the one with the foot pedal and you have to be the one turning on the radiation. It doesn't matter who turns on the machine. It's the positioning of the equipment and the use of the foot pedal at the time that the injection is being done, and that has to be done by the individual doing the procedure in order for it to be done appropriately. I don't know specifically what this bill implies in regards to that but I think that's an important point.

SENATOR JENSEN: Thank you, Doctor. Is there any question...Senator Cunningham.

SENATOR CUNNINGHAM: Just really quick. Doctor, I'm not an expert by any means in this area, so I apologize if I'm out of line here but the way I read it, the CRNA can do it now, currently, if a veterinarian is in the room overseeing? Is that correct?

PHIL ESSAY: I don't know that.

SENATOR CUNNINGHAM: I believe that's the way it is now.

PHIL ESSAY: That doesn't necessarily make it right.

(Laughter)

SENATOR CUNNINGHAM: Yeah. Well, but you get my point. Thank you.

PHIL ESSAY: Yes, sir.

SENATOR JENSEN: Any other questions? And, Doctor, can we also use your testimony for the next bill, too?

PHIL ESSAY: Yes, please do.

SENATOR JENSEN: Okay, thank you very much. Anyone else wishing to testify in opposition? And is there anyone else after this young lady? One more? Okay, thank you.

SHEILA ELLIS: (Exhibit 4) My name is Sheila Ellis, E-l-l-i-s, and I'm a board certified anesthesiologist who has practiced for ten years at the Nebraska Medical Center. I am here in the capacity today as president of the Nebraska Society of Anesthesiologists, and I'll abbreviate my remarks in the interest of time. I am not a pain physician. I have never provided any of these procedures under the use of radiology imaging, although I do do the other procedures such as epidurals, spinal blocks, and peripheral nerve blocks because I don't have the competence or the training or the advanced training that it requires. As it's already been stated explicitly, there are significant risks involved in placing needles and injecting medications including temporary or permanent injury, disability, or even death. This bill does not have any provision to require a minimum training standards or qualifications, certification, continuing medical education, or reexamination of any individuals who are performing these invasive or potentially risky procedures, and there is also no limitation on the specific type of procedure that can be performed. Anesthesiology as a medical discipline has a well-earned reputation completely focused on patient safety. There are multiple notations in the national press about anesthesiology safety record and leadership in patient safety, including being the only medical specialty to be cited in the Institute of Medicine's report "To Err is Human" that was published in 2000. I firmly hold that patient safety is of paramount importance, and I believe

this bill does not have the adequate provisions to ensure the safety of patients who are receiving these advanced medical procedures because of the lack of requirement for training, competency, or certification in this bill, and the safety of patients undergoing these procedures must be our top priority at all times. Thank you for your consideration, and I'll take any questions.

SENATOR JENSEN: Thank you, Doctor. You, of course, recognize Nebraska and its rural nature, and we have a large amount of the state that does not have anesthesiologists that can be at various hospitals and whatnot. Are we restricting those areas then to say that they cannot do this procedure or...unless there is somebody that...an anesthesiologist that can go there and do that?

SHEILA ELLIS: Well, there are pain specialists that are at various points throughout the state and there are many specialized medical procedures that we're not able to provide at every single hospital. And my parents live in Cordova, Nebraska, population 108. And I want them to receive the same standards and excellent medical care that could be given here in Lincoln.

SENATOR JENSEN: Thank you. And again, can we use your testimony for the next bill also?

SHEILA ELLIS: Yes.

SENATOR JENSEN: All right. Thank you. Next testifier please?

BARBARA HURLBERT: Thank you, Senator Jensen, for allowing me to testify today. My name is Barbara Hurlbert, H-u-r-l-b-e-r-t. I'm a professor of anesthesiology at the University of Nebraska Medical Center. However, today I'm testifying on my own behalf and not for the Medical Center or the organization. I am also the education director for the residency program at the Nebraska Medical Center, and I'm proud to have been on the staff at the Med Center for 31 years and have been teaching residents. I have currently taught over 300 residents anesthesia. During this time I have trained them well. We started in the state of Nebraska when I became an anesthesiologist teaching in 1974 only

having anesthesiology, M.D. anesthesia, in Lincoln and in Omaha. And you currently know that we are now in Norfolk and Grand Island and North Platte and Scottsbluff and Hastings. And the access to M.D. anesthesia has increased over the years that I have been in practice. What I'm concerned about is this bill does not provide anything or has no provisions for what kind of education you need to do to do this procedure, what competency provisions are there, and I'm very, very concerned about patient safety, which I have been all my life and that's why I've been training the residents that I have trained. And I want to tell you that I, even though I train residents on a daily basis, the residents that leave my program have had one month of pain training. And they are not qualified to do fluoroscopy and the training that we're talking about. I have trained CRNAs. They are not taught in our program here at the Nebraska Med Center to do the procedures that we are currently talking about. It takes advanced training. Now we do have a fellowship. It takes a year. And we do have people who can come and speak to you about the fellowship and about the training that exists. But I want you to realize that if anesthesiologists are concerned, and anesthesiologists are not trained in knowing exactly under fluoro where this needle is. And I would hesitate to do this, even though I have practiced 31 years and have taught residents on a daily basis to do epidurals and to do spinals and to do regionals in a perioperative period, which is completely different than this. I'm very concerned about letting this bill go forward as far as education and competency in our state. And that's all I really wanted to say, and I thank you, Senator Jensen, very much for understanding. I think we need to get the idea that it takes another step in education, that it is truly a fellowship-trained, not going to two courses or five courses or ten courses over a year's period of time.

SENATOR JENSEN: Thank you. Senator Cunningham.

SENATOR CUNNINGHAM: Yes. Thank you for coming. In your opinion then, who is qualified to use the fluoroscopy?

BARBARA HURLBERT: I think people who are trained, fellowship trained in regional and...

SENATOR CUNNINGHAM: Well, just give me an example of what their title might be who those people are.

BARBARA HURLBERT: Anesthesiologists, M.D.s, M.D. radiologists...

SENATOR CUNNINGHAM: But not all anesthesiologists.

BARBARA HURLBERT: Not all anesthesiologists. They have to be fellowship trained. There is an extra board certification beyond being boarded in anesthesia to do pain medicine, Doctor...uh, Senator. And that's an extra year of training, an extra set of testing, an extra check in competency for these people. In fact, two of the people that have testified, Dr. Massey and Dr. Essay, I actually trained as residents. I am very proud of them but they have gone on to do extra training that I have not had. And I think people need to realize that. And radiologists also have that training.

SENATOR CUNNINGHAM: I would note that...

BARBARA HURLBERT: Private practitioners and family practitioners do not.

SENATOR CUNNINGHAM: I would note that you called me doctor, and I am...

BARBARA HURLBERT: I'm sorry, Senator.

SENATOR CUNNINGHAM: ...April 13 I am looking for a job. Do you see... (Laughter)

SENATOR HURLBERT: I'm sorry, Senator. In my haste to answer you...I'm so used to talking to physicians at the Med Center only. I apologize.

SENATOR JENSEN: Any other questions? And, again, can we use your testimony for both bills?

BARBARA HURLBERT: Yes. Thank you so much.

SENATOR JENSEN: Thank you very much. Anyone else wishing to testify in opposition? Any neutral testimony?

DAVID BUNTAIN: Senator Jensen, members of the committee, I am David Buntain, B-u-n-t-a-i-n, attorney and lobbyist for the Nebraska Medical Association, and I just want to touch on a couple of points. Obviously, this is an issue where there is a disagreement within the medical community, and we are aware of it. We became aware of it this fall. We have our legislative commission meeting next Monday. This matter was discussed at a November meeting. I did indicate to the lobbyist for the CRNAs that this was something that we could not support at that time. We are still working on the issue. I really think that this is something that needs to be worked out and it's not as simple as making this amendment to this bill. And let me just suggest that part of the reason we're having this problem is because of the statute that we're trying to amend. What you are working on is a section to the Radiation Control Act. This Radiation Control Act was passed to regulate the use of x-ray machines. It's been...and I meant to look at this but I think it's been at least ten years, maybe longer, since we've done any significant amendments. I know you've got another bill you're going to look at to make some housekeeping-type amendments. If you read the list of people who are excepted from the training requirements, they are the professions that use x-ray equipment. That's what's at issue here. And I would submit that if, for example, the nurse practitioners who are involved in the other bill, were simply asking to be exempted for x-ray equipment, I think that would be acceptable. I mean, again, we haven't voted on it but I think that would be acceptable. What is really driving this is the change in technology that has allowed the kind of remarkable diagnostic and therapeutic procedures that Dr. Massey talked about. That really wasn't contemplated when we excepted these practitioners from the training requirements. And it seems to me that what we really ought to do as medical providers, and also as a Legislature, is to take a step back and say, what is necessary to protect the health and safety of the patients that we're serving. And it strikes me that the way to do that is through going through a credentialing review process where the kinds of issues that are being debated here can be discussed. It really is a scope of practice issue that comes about because of this change in technology that allows this kind of therapeutic practice that wasn't really

contemplated when we were working on the law. And so, that's why I think the Medical Association wants to help the groups involved, the rural physicians who really want to benefit from this, anesthesiologists, and our pain management specialists who are concerned about the implications of this, and the Legislature which is probably...you're probably sitting there scratching your heads saying, how do we resolve this? Because I think it is something that it's not simply a matter of dropping a few words into the statute. I think that there needs to be more done in order to protect the public. And those are the kinds of issues that the medical community is wrestling with right now.

SENATOR JENSEN: Thank you. Any questions from the committee? I appreciate your comments.

DAVID BUNTAIN: Thank you.

SENATOR JENSEN: Anyone else wishing to testify in a neutral testimony? Senator Cunningham, do you wish to close?

SENATOR CUNNINGHAM: Thank you, Senator Jensen, and committee. I apologize for the length of the hearing. I didn't realize it would go this long but some of this wasn't my fault. (Laughter) That's a joke. Anyway, I would remind you, though, there's obviously a lot of opposition to this bill but according to Ron Jensen anyway, Dr. Raymond who was a chief medical officer at the time, did not think this required the 407 process, so I would remind you of that. Dr. Fitch from O'Neill talked about all of the doctors who have signed on as proponents of this bill. And Senator Jensen, you mentioned the differences in rural Nebraska. I don't want to do anything that's going to harm patients in rural Nebraska but I want to make sure they get the care that they need. I want to make sure that, you know, if we aren't able to do this that it's really legitimate that we shouldn't do it. So I promise to work with this committee in any way that we possibly can to get the answers, whether it be education requirements or what it may be, and go forward from there.

SENATOR JENSEN: Thank you, Senator. Any questions? Seeing none, that will close the hearing then on LB 838. (See also

Exhibits 5, 6) Senator Price is here to introduce LB 908. Senator Price, I don't think you were aware of what we did and then didn't do. We said we were going to have a joint hearing and then later on said we were not.

SENATOR PRICE: Yes.

SENATOR JENSEN: However, I think that we can take the testimony in the opposition of the last bill and use that same testimony on yours, those that anyway said we could do that. So with that, please, we welcome you and please go ahead on your introduction.

LB 908

SENATOR PRICE: Good afternoon, Senator Jensen, and members of the Health and Human Services Committee. I am Marian Price. I represent the 26th Legislative District in Lincoln, and I'm here to introduce LB 908. It's always nice to be back in front of this committee. This bill amends the Radiation Control Act to allow advanced practice registered nurses to interpret or direct diagnostic x-ray procedures without specific training requirements. The purpose of LB 908 is to put advanced practice registered nurses on parity with other medical professionals such as physicians, dentists, and physician assistants who are exempted from the rules and regulations concerning radiation-generating equipment. There are going to be people who are going to be following me, immediately following me, is a nursing professional who's going to testify for LB 908 and answer your questions. I apologize for the movement inside and out of the room but we were having quite a good brief meeting outside, and so we have come to an area that is a little muddied but we're going to offer some testimony which I hope will clarify this. And so I look forward to your questions. Are there any questions at this point?

SENATOR JENSEN: Senator Price, are you aware of a letter that...well, it was dated today, so maybe you're not...from Joann Schaefer, the Chief Medical Officer?

SENATOR PRICE: Yes.

SENATOR JENSEN: You have seen that one?

SENATOR PRICE: Yes.

SENATOR JENSEN: Yes. Okay. Fine.

SENATOR PRICE: And that was part of our discussion outside.

SENATOR JENSEN: Okay.

SENATOR PRICE: And so you will hear more about that also but, yes, sir, I did get a copy before the hearing.

SENATOR JENSEN: Okay, thank you. Any question for Senator Price? Always good to see you. Welcome.

SENATOR PRICE: Thank you.

SENATOR JENSEN: With that, we're ready for the first proponent testimony on LB 908. Thank you.

TOM VICKERS: Senator Jensen, members of the committee, for the record, my name is Tom Vickers, V-i-c-k-e-r-s, registered lobbyist for the Nebraska Nurses Association. And, in case you're wondering, I am not a medical professional at all. I find myself this afternoon in a position of an ex-rancher, ex-state senator, and a lobbyist for a number of years. And I think what we're attempting to do is...I think David Buntain put it pretty well. We were attempting to amend a statute, at least from our perspective and speaking more particularly for the nurse practitioners, nurse midwives, dealing with x-ray machines. I think it's probably very legitimate for this committee to look at the changes in the statutes. It was not our intent at all to expand the scope of practice for the nurse practitioners or the nurse midwives. The CNS's can't operate the equipment, as I understand it, under their scope of practice anyway, from last year. I think Senator Johnson's bill, from what I gather with visiting with the department, goes quite a ways to try to address the issue that we were concerned about and we appreciate that. But I would suggest that this committee, as David Buntain mentioned to you, take a long hard look at the way we regulate the medical profession given the changes in technology that we have seen in the last few years and

probably will continue to see. And we'll pledge to you that the Nebraska Nurses Association will help and participate as much as we can, although we'll tell you that I don't know how David Buntain does it or how the doctors do it but the nurses are good about asking us to get bills introduced and they're working hard. So in answer to some of these questions earlier about who's running Beatrice hospital, it must be the nurses down there, Senator, because they're not here today anyway. So it's pretty bad when they have to send me up here but if you have any questions, I'll attempt to try to answer them.

SENATOR JENSEN: Thank you. Any questions? I don't see any, Tom. Anyone else wish to testify in support?

ROGER KEETLE: Good afternoon. For the record, my name is Roger Keetle, K-e-e-t-l-e. I'm a registered lobbyist for the Nebraska Hospital Association and we were in a position to support LB 908 for the same reasons we testified in support of the other bill. And nothing is simple. And I want to pledge our association's concerns about trying to come up with a better way to deal with this issue than perhaps the language you see before you. And I look forward to working with whomever in the department to get things squared away. With that, I'd take any questions.

SENATOR JENSEN: Thank you, Mr. Keetle. Any questions? Seeing none, thank you.

ROGER KEETLE: Thank you.

SENATOR JENSEN: Anyone else wish to testify in support? Now in opposition, we do have those testimonies that were given and we can also include those into this bill. Is there anyone who wishes to testify in opposition that we have not heard from on the previous bill? I don't see any. Anyone in a neutral capacity? I don't see any. Thank you. That will conclude the hearing on LB 908 and also LB 938 which we had heard before. Oh, excuse me, Senator Price. I'm sorry. My goodness.

SENATOR PRICE: I'm easy to overlook, Senator Jensen. (Laughter)

SENATOR JENSEN: Yes.

SENATOR PRICE: Listen...

SENATOR JENSEN: You don't have a bullhook, do you? No, I'm sorry.

SENATOR PRICE: Sir?

SENATOR JENSEN: I didn't know if you had a bullhook with you that you were going to use on me. (Laughter)

SENATOR PRICE: It's a concealed weapon. (Laughter)

SENATOR JENSEN: Okay.

SENATOR PRICE: Listen. You can feel the air of working together with the groups that are uncomfortable with this and with my side, which is the nursing professionals. And we do want to work together because, as a registered nurse myself, we do want to always put the care of the patient and the safety of the patient ahead of time. We don't want anybody to have permission to go foolhardy into this and risk injury and death. And so we will work together and, for you that are not term limited, you'll be seeing this again. And I thank you very much. Any questions?

SENATOR JENSEN: Senator Cunningham, you have a comment or question?

SENATOR CUNNINGHAM: Just a comment, Senator Price. I don't know if you've noticed the way Senator Jensen handled this bill but because of the way he did it I took all of the brunt of everything. You noticed that?

SENATOR PRICE: Yes. Yes, I agree. And for those that did identify opposition to LB 908, I do want that clarified, too, because some of them did not refer to LB 908. And so, give me my fair share of opposition but give more to Senator Cunningham. (Laughter)

SENATOR JENSEN: Thank you.

SENATOR PRICE: Any questions, comments?

SENATOR JENSEN: I don't see any.

SENATOR PRICE: Thank you very much.

SENATOR JENSEN: That will conclude the hearing on LB 908 now and we'll open on LB 882. By the way, I would like to have for the committee members a short exec session right afterwards, okay? Arnie, is that okay? We'll do a short exec session after. Okay?

LB 882

SENATOR JOHNSON: Senator Jensen, I'm Senator Joel Johnson, J-o-h-n-s-o-n, introducing LB 882. This is what might be considered a cleanup bill but, as we discovered, there's a little bit more to be cleaned up than what we thought there might be. Let me do this first. Let me go through the different portions of this cleanup bill, which I think there is quite general agreement, and then we will save the last section where there is some controversy and address that last. First of all, LB 882 makes it possible for the department to impound or order the impoundment of sources of radiation. This is if a source of radiation had been abandoned and in possession of a person not equipped to observe or failed to observe the provisions of the Radiation Control Act. This is necessary so that the department can dispose of the impounded source of radiation. One of the next steps is this: it eliminates the requirement of the department to provide forms for registration of radiation. Rather than going through the standard paper trail that we have had over the years, you can now use different things like e-mail and so on. And, again, I don't believe that there would be any controversy here. It's just the matter of how the application and correspondence is carried out. Next, is it eliminates the reference to the Central Interstate Low-Level Radioactive Waste Compact Commission. Since this state no longer belongs to the Compact Commission, this would seem to be a reasonable portion. Next, LB 882 eliminates all references to provisional licenses for radiographers. All provisional licenses have been expired. There's no longer a need for that. I'm going to skip the next section here for just a second and go to

one or two more areas that are relatively easy and, I think, noncontroversial. LB 882 creates a new category of a limited radiographer in bone densiometry equipment and allows the department to recognize the successful completement of this operator's examination. I think we all know what bone density is meant to determine and so on. And then, last, under the Radiation Control Act, only licensed practitioners can interpret medical radiography procedures or direct medical radiographers and limited radiographers to perform medical radiography. This is inconsistent with the duties and scope of a practice of physician assistants and nurse practitioners that include ordering and interpreting medical radiography procedures. This bill modifies the definition of the licensed practitioner to include these physician assistants and nurse practitioners. Now let me get back to the area where there is some controversy. And I think, in many ways, what we have is not truly what I would call a controversy. What the definition, or what we were supplied with, is this. LB 882 creates a new restricted category of medical radiography licensure. Basically what we have with the new technology, as it has evolved over the years, is the CT scan people, which is a computed tomography, that has been kind of one specialty. The other one is where you have used nuclear...I guess the isotopes might be the best way of describing it, where you would give an injection into the person and then do a test and follow what happens to that isotope. Well now people have come along and combined these two techniques. And so the question then becomes, how do you license these two areas? And leave it to the people from HHS to comment exactly from their standpoint but the question that I have received about this is that we have made it so that we have made two categories when, in many instances, there is only one category. And then the next situation is, how about next week or next year when there is a new machine that might use these in a slightly different way? So in an attempt to keep up with expected anticipated changes in technology, this is an area here that probably deserves reworking in consultation with some of the people that we will hear from this afternoon, as well as our friends from HHS. And I would offer to facilitate any discussions along these lines with these two groups. I do not think that they're insurmountable in any way.

SENATOR JENSEN: Thank you, Senator Johnson. Any questions? Seeing none, we're ready for the first proponent. Director Nelson, welcome.

DICK NELSON: (Exhibit 1) Thank you and good afternoon, Senator Jensen and members of the Health and Human Services Committee. I am Dick Nelson, N-e-l-s-o-n. I'm director of Health and Human Services Finance and Support. This is actually a regulation and licensure bill. Dr. Schaefer is out of state today working on protecting the citizens of Nebraska from bioterrorism. And, as the former director of R&L, she asked if I might come over and present this bill. We do want to thank Dr. Johnson and Senator Johnson for introducing this bill on behalf of the Health and Human Services System. And I am here to testify in support of LB 882. I might mention, just by way of quick introduction and so people will be aware of this, we are going to suggest two amendments to the bill as introduced this afternoon. Senator Byars had pointed out earlier this afternoon we like to suggest wording changes to other people's bills, and we thought it was so much fun we'd suggest some to our own. LB 882 makes the following changes in the Radiation Control Act. First, in the event of an emergency affecting occupational or public health and safety or the environment, Section 71-3516 of the act authorizes the department to impound or to order the impoundment of sources of radiation but does not allow the department to take title or dispose of them.

SENATOR JENSEN: Is that new? Have you ever had that authority before to impound?

DICK NELSON: No, we have the authority to impound right now, Senator. And back in 2003 was the only time we had to exercise it but we did impound...I've got it written down here...a portable moisture density gauge, which is an item that's probably about 2 feet long and maybe a foot wide and 18 inches high or something like that. It weighs about 40 pounds. It's used by engineering firms in similar organizations to test soil compaction, and it does it with radiation. And we had to seize such an item, or impound it, I'm sorry, to use the correct term. Once we impounded it, we couldn't do anything with it. And at this point, it is safely stored by another state agency that uses radiation

equipment and they had a place to keep it but it's been sitting there for two and a half years and something needs to be done with it. So in this case or in any future case, we would ask to have authority to dispose of those particular items. We could use several different options such as returning it to the manufacturer, disposing of it at a low-level radioactive waste facility, selling it, or I might add transferring it to another state agency that uses that kind of equipment. Second, in Section 71-3507, subsection (9), we are required to provide forms for the registration of sources of radiation. LB 882 would eliminate the requirement that we provide the actual forms for the registration. For example to register an x-ray machine, today the applicant must fill out a particular paper form and mail it or bring it to the office. But this would allow the department the flexibility to list in the regulations the necessary informational items that must be included in the application without limiting it to a particular format, and would allow the applicant flexibility in how they report. Applicants, for example, would have the flexibility of providing the required information electronically to the department in a convenient format. We can still provide the forms for those who wish to use it but we would like to move a little more toward E-government in this area. Third, Section 71-3503, subsection (23) includes a reference to the Central Interstate Low-Level Radioactive Waste Compact Commission in the definition of "management of low-level radioactive waste." LB 882 would eliminate this reference, since the state is no longer a member of that compact. The department respectfully suggests an amendment to that section, and we have attached that to my testimony. We realize that when we struck some words we did not strike enough words. And we would propose now striking the entire phrase "except the commercial disposal of low-level radioactive waste in a disposal facility." With that change, the definition would read as follows, and this would be a definition of some of the jurisdiction that we have. We would have jurisdiction over management of low-level radioactive waste means the handling, processing, storage, reduction, and volume disposal or isolation of such waste from the biosphere in any manner. We just clarified now that the low-level radioactive waste commission is gone that the jurisdiction over that type of item would return to the department where it was previous to the formation of the

compact. Fourth, Section 71-3515.02, subsection (4) would be removed from the act. The subsection is outdated since all provisional limited radiography licenses have expired. That was a transitional provision put in a number of years ago. Fifth, Section 71-3515.01 currently limits the operation of x-ray computed tomography or CT equipment by nonexempt individuals. It limits that operation to medical radiographers. Recently, a new type of medical imaging equipment has been developed that combines both a CT system and a nuclear medicine imaging system in a single imaging procedure. Nebraska regulations for control of radiation require that the nuclear medicine imaging part of the procedure must be performed by a nuclear medicine technologist because of the use of radioactive materials. So we now have regulations that would require both a medical radiographer and a nuclear medicine technologist to operate a single piece of equipment. LB 882 would create a new restricted category of medical radiography licensure. This category would allow individuals certified by the Nuclear Medicine Technology Certification Board or the American Registry of Radiologic Technologists in Nuclear Medicine Technology...and I thought Health and Human Services Finance and Support was a long title...it would allow them to be eligible for a license to practice restricted medical radiography. They would be restricted to the use of CT systems that are designed to perform both the function of a nuclear medicine system and a computed tomography system. Six, Section 71-3515.01, subsection (2) authorizes limited radiographers to perform only routine radiographic procedures. In 1997 the Radiation Advisory Council recommended to the department that bone densitometry, which is used to diagnose and evaluate the effects of osteoporosis, be deemed a nonroutine procedure. In response, the department allowed only licensed medical radiographers to perform radiographic procedures using bone densitometers. Subsequent to that decision, the department reviewed the bone densitometry equipment and the equipment manufacturer's recommendations for operator training. As a result of the review, the department issued a policy in 1998 allowing limited radiographers to perform bone densitometry procedures on the regions of the human anatomy for which they were licensed. The state currently uses the American Registry of Radiologic Technologists Limited Scope of Practice in Radiography examination in making credentialing

decisions for other limited categories of radiographers. The American Registry recently developed a limited scope examination on the principles of operating bone densitometry equipment specifically for use by states in making a determination of an individual's eligibility for state licensure. Therefore LB 882 would create a new category of limited radiographer in bone densitometry and would allow the department to recognize successful completion of the American Registry's bone densitometry equipment operator examination as the basis for limited licensure in bone densitometry. We do not believe this change requires a 407 review. Through the policy described above, this professional practice is currently allowed. The recent creation of the specific testing simply provides a basis to move from policy determinations to a more formal licensure category. Seventh, under the current Radiation Control Act, only licensed practitioners can interpret medical radiography procedures or direct the activities of medical radiographers and limited radiographers in the performance of medical radiography. The current definition of licensed practitioners does not include physician assistants or nurse practitioners. This is inconsistent with the duties authorized in the scope of practice for physician assistant and nurse practitioners which includes ordering and interpreting medical radiographic procedures. LB 882 would modify the definition of a licensed practitioner to include physician assistants and nurse practitioners. It is at this point, members of the committee, that we have yet another amendment that we would like to offer today. This relates in concept to some of the testimony that you have heard earlier today on several of the other bills. The intention of the department in introducing this particular language was to clarify that physician assistants and nurse practitioners can continue their current practices with regard to x-rays. It was not intended to move forward into the area of fluoroscopy. The two bills that were presented earlier today on which you heard testimony dealt with fluoroscopy. I understand, after talking with Senator Price, that she had not intended to move to fluoroscopy either. So this is a very complex area and it's very easy to understand why people are wrestling with this. An earlier testifier, Mr. Buntain, mentioned that the Radiation Control Act had not been updated for a number of years and we're being overtaken by technology. That's part of the

issue that we are dealing with. But I am proposing on page 9, beginning on line 6, to strike beginning with the third comma through "practitioner" in line 7 and insert a new sentence: "Licensed practitioner also means a physician assistant or nurse practitioner except for the purposes of directing, performing or interpreting fluoroscopic procedures." In other words, we're intending to limit this to the kinds of x-ray that Dr. Johnson himself indicated. That's pretty much routine stuff and we are quite certain within the scope of their practice that many physicians assistants and nurse practitioners are doing that today. It has come to our attention that that's really not allowed under the Radiation Control Act, so that's what we would like to try to clarify with this proposal. Thank you for the opportunity to testify and to offer a couple of amendments to our own legislation. And I would be happy to answer any questions you may have.

SENATOR JENSEN: Any questions for Director Nelson? I don't see any. Thank you.

DICK NELSON: Thank you.

SENATOR JENSEN: Anyone else wish to testify in support?

TOM VICKERS: Senator Jensen, members of the committee, I'm still Tom Vickers, and it's still spelled V-i-c-k-e-r-s. I'm a registered lobbyist for the Nebraska Nurses Association here in support of LB 882 and as you were just explained to you...and as amended by the department with the amendment that Dick Nelson just offered to you. It was our intent all along to not expand the scope of practice to the nurse practitioners. We just happened to pick the wrong section of the statute to try to amend. Senator Johnson is obviously a lot smarter than we are. We thank Senator Johnson for introducing this bill and we hope you would accept the amendment. I'd be happy to answer any questions.

SENATOR JENSEN: Thank you, Mr. Vickers. Any questions? I don't see any. Anyone else testifying in support? Anyone in opposition? Anyone in neutral testimony? Are you a neutral or are you in opposition?

ROGER KEETLE: I'm a neutral.

SENATOR JENSEN: Neutral, okay.

ROGER KEETLE: And is he in opposition? If so, it's...

DAN GILBERT: I'm not in opposition.

ROGER KEETLE: Okay. Good afternoon. For the record, I'm Roger Keetle, registered lobbyist for the Nebraska Hospital Association. This is one of the bills that's on our monitor list to try and figure out what all of this meant. I appreciate the testimony from Director Nelson. I also very much appreciate his last suggested amendment to deal with the nurse practitioners and the physicians assistant issue on basically normal x-rays, which was sort of the objective of some of the other bills we've talked about today. So with that, we have not yet taken a formal position. Again, this language has some real promise, and we'd like to try and see if we could work to make sure this does what we think it does. So with that, I'd take any questions.

SENATOR JENSEN: Thank you. Any questions of Roger? Senator Stuthman.

SENATOR STUTHMAN: Thank you, Senator Jensen. Roger, earlier this afternoon we had the pleasure of being lobbied by the Nebraska Hospital Association, which you are a part of, by a Barb Person. What happened (inaudible)? We enjoyed her.

SENATOR JOHNSON: Bring cookies trays.

ROGER KEETLE: I'm going to start bringing food around. Every now and then, the Hospital Association hires experts to work on certain issues and it's nice to have fresh faces. And Barb really is good at hospital bylaws and those issues, so that's why she's doing this issue.

SENATOR STUTHMAN: I was enlightened with her presence.

ROGER KEETLE: Well, she did an excellent job.

SENATOR STUTHMAN: Thank you.

ROGER KEETLE: I won't tell my boss you said this. Thank you.

DAN GILBERT: Good afternoon, Senator Jensen, and members of the committee. My name is Dan Gilbert, G-i-l-b-e-r-t. I am currently the Chairman of the Board of the Nebraska Society of Radiologic Technologists. I am also a program director for the School of Radiologic Technology at Regional West Medical Center in Scottsbluff. I stand before you, or sit before you, neutral on this. I am very much in support of the concept of LB 882 in terms of providing an opportunity for nuclear medicine technologists and radiographers to begin using fusion studies in Nebraska. However, I have a strong opposition to the way in which the bill is offered. Currently there are two tracks of many tracks in diagnosing pathology and radiology. One is nuclear medicine which uses radioactive material to identify metabolic or physiological changes in the body. CT provides that anatomy. The concept that we now have, with new technology, is fusing those two types of images together, so that we can localize those changes in pathology on an anatomical image, which provides much more information in terms of assisting in diagnosis and treatment. Most hospitals in the state are currently using two separate systems. There is a CT unit and then a PET unit, and then they combine the two images together by software. In about 2000, there was the beginning of a production of one unit that did both procedures. They were sequential of each other. In 2004, nationwide there are only about 400 technologists who have certification both in nuclear medicine and in CT. For the state of Nebraska, I didn't have any numbers in terms of people who had dual credentials there but of the 1,788 technologists in the state, 191 are credentialed in CT and 62 in nuclear medicine. That means that...like I said, I don't know whether or not there were any individuals with dual certification, but that significantly limits the availability of technologists to do both of those procedures. So the concern that we have is is that the way that the bill is stated is that a nuclear medicine technologist who completes the certification for CT will not be able to do CT procedures other than on a machine that offers both CT and PET scanning. This individual, taking the certification exam, will have done exactly the same requirements in terms of competency exams and taken the same

test as a radiographer who has taken that same exam. With the limited numbers of technologists who are certified in CT in the state, to me this seems rather an unfortunate way of using these individuals. As I said, there was only a very few machines that actually have this hybrid situation where there's both CT and PET, and so these people would basically be limited to using those few pieces of equipment, whereas a nuclear medicine technologist who is certified in CT would be able to help departments in those areas where they need help in CT if there was nothing going on in nuclear medicine at the time. So I am suggesting that on page 22, line 6, we just basically strike everything after "systems," and everything in line 7, so that it would just read that "a person licensed by the department as a medical radiographer restricted to tomography may practice medical radiography on any part of the human body using only computed tomography for interpretation by and under the direction of a licensed practice physician or practitioner." To me that would be the best use of human resources for technologists in the state. And that's what I have to offer. Thank you.

SENATOR JENSEN: Thank you. Any questions? Thank you for coming all that way. Anyone else in neutral testimony? Come forward please.

MARCIA HESS SMITH: (Exhibit 2) Good afternoon, Chairman Jensen, and members of the Health and Human Services Committee. My name is Marcia Hess Smith, and I am a certified nuclear medicine technologist, and I am the program director for the nuclear medicine education program at the University of Nebraska Medical Center though I am testifying today in the capacity of an individual citizen. I am testifying in a neutral respect today though I am, again, also in favor of the general concept of this bill that we are taking steps forward to try to bring Nebraska's law and regulations up to a place where we're trying to catch up with technology in the state, though I do have issues with the particular wording of the bill and how it will limit the practice of medical professionals in the state. Just to give you a little bit of background, every day I spend time educating students with the most current growing and emerging trends in the radiological sciences, specifically in advancements in nuclear medicine areas such as Positron Emission Tomography, also known as PET imaging,

and the fusion imaging modalities that have developed with PET when PET was combined with computed tomography or CT scan imagers into what's call PET-CT scanners or fusion imagers. The images created by these fusion imagers takes both anatomic data from CT scan images and puts it with metabolic images from the PET scan images and provides radiologists and radiation oncologists dynamic images of patients' tumors and neurological data and cardiac data alike. PET scans are traditionally performed by nuclear medicine technologists, and CT scans are performed by radiographers. The fusion of these images and these machines now requires the state of Nebraska to examine the qualifications of the technologists who perform these examinations. The technology has been emerging for several years and the regulatory bodies throughout the country have struggled to keep up the laws that allow for who can and cannot operate these new technologies. And those of us in the field and in the state applaud the efforts to adapt to the changing technologies, and we also need to look forward to the future changes that will come. I'm going to try to summarize my testimony. I realize I just handed you this large document. I'm not going to read all of it but I'm going to hit the three major points, and then the additional information will be available in the testimony for you to review. One major consensus conference that happened about four years ago brought together representatives from all radiological organizations that I have listed here. But the two big ones were the Society of Nuclear Medicine and the American Society of Radiologic Technologists. And those provided representatives from sort of the CT world and the nuclear medicine world. And the conclusion that this consensus came to was basically we don't really care who runs this equipment, whether it's CT people or nuclear medicine people, as long as they are qualified people. However, they did recognize that there are very short numbers of these people who are in existence at that time, and there still are. There are actually less than 200 nuclear medicine technologists who are also CT board certified in the United States. And for some reason, over 100 of those particular types of technologists live in Florida. Sunny weather...I don't know. But we don't have many of them here. As a matter of fact, most of the nuclear medicine, being a small community, I don't believe there any nuclear medicine technologists in the state of

Nebraska who are CT certified. So we're lacking in those professional people. The other major consensus that they came to was that it's difficult for professionals to always get those certifications, those board certifications. So instead, they recommended that multiple pathways be created to educate or train registered nuclear medicine technologists, radiographers, and radiation therapists to operate PET-CT equipment. Following this effort, they developed a curriculum that was developed for the new emerging technology that was put out by the ASRT, the American Society of Radiologic Technologists, and the Society of Nuclear Medicine, called the PET-CT curriculum, endorsed by both of those major professional organizations. With regard to this bill that we are discussing today, it is attempting to change the laws that allow nuclear medicine technologists to perform in the area of computed tomography. Historically this was a field that radiographers crossed into because of the x-ray background. But with fusion technology we have created new equipment, new images, scanning capabilities, and we are creating new technologist professionals. And that new technologist has this new name, the fusion imager. We need to look at this in a new way that we've never looked at before. Nebraska currently has...somebody mentioned in their previous testimony that the Nebraska RAD Act was developed several years ago and the emerging technology has moved beyond the scope of it in many ways. One problem that the state of Nebraska has is that medical radiographers are licensed and nuclear medicine technologists are not. And that has been an issue when we even try to look at rewriting the law with regard to this. But one thing that this bill has...you know, the intent of this bill is good. The consensus of everyone in the nuclear medicine and imaging profession wants to see doors open for imaging professionals to expand their education, to grow with the emerging technologies. While this bill is trying to create new licensed medical radiographer positions for nuclear medicine technologists, it's too restrictive in its language and scope. The bill creates a medical radiographer restricted to computed tomography, but only on a computed tomography system designed to perform the functions of both a nuclear medicine-computer tomography system. So you can do it but you can only do it on this piece of equipment. The impact of that is that with emerging technology you won't be able to do it on the next phase of equipment. You

won't be able to do it on the piece of equipment over here or down the hallway. With equal credentials and equal training, you won't be able to perform equal jobs. The current proposal limits fully qualified board CT technologists to only one type of imaging equipment and, also with shortages of personnel, that's a problem. The board exams administered are the same. The board exams were changed when in 2005 the board exams were opened up to nuclear medicine professionals, they were changed to incorporate certain areas of the physics and the curriculum that used to not be in there if you were an x-ray tech. Now the board exams are directed so that nuclear medicine technologists are board certified and tested in all areas that x-ray technologists previously were tested in. I believe that the state has concerns that a nuclear medicine technologist does not have the background that an x-ray technologist has to go into CT, and so they want to restrict the scope of their practice. However, the board registration exam has made sure that the professional who is taking this exam is tested in all areas of the curriculum to make sure they are tested in those. They have the same clinical procedures that they have to test out of, the same didactic procedures that they have to test out of. And in the end, they are the same CT professional as an x-ray technologist who has tested out of and who has accomplished that board CT registry. With regard to the multiple pathways of education, the state of Nebraska thus far has focused on one pathway to meet the demand for fusion technologists, and many states have addressed these issues differently. I am currently unaware of any nuclear medicine technologists in the state of Nebraska that are dual-certified. And this means that the value of multiple pathways of the educational process discussed at the consensus conference and endorsed by the ASRT which is the American Society of Radiologic Technologists, would be of great value to the healthcare community in Nebraska. Some technologists would be training while working in full-time jobs, others would be educated in traditional programs, the universities and colleges. The board certification process can be long and difficult, and the pass rates are low delaying patient access times due to staffing issues. And we would like to be able to have nuclear medicine technologists be able to prove competency by completing a state board-approved course of study in fusion technology

based on the ASRT and Society of Nuclear Medicine joint curriculum as an alternate pathway to becoming a fusion technologist. Currently in the state of Nebraska, there are other technologies, including nuclear medicine, where you don't necessarily have to be board certified but you do have to complete training programs. And we would like for the state to also consider that this be an alternate pathway, as well as board certification. These are advanced programs. These are professionals who have already become board certified in a primary program. And to limit the scope to only board-certified professionals will be limiting to healthcare and limiting to the professionals who can be trained in these fields and move forward and help meet the demands of future technology and who can work in those fields. This is a model that has been endorsed by the ASRT and was recently adopted by the state of New Mexico. Additionally, we would like to address concerns about the fact within nuclear medicine combined CT scanning technology, because there are various types of equipment that range all the way from true CT scanning down to using only very small, nondiagnostic amounts of CT in certain types of nuclear medicine equipment...in other words, there are nuclear medicine scans that are hooked to full-blown CT scanners and there are nuclear medicine SPECT cameras that are hooked to a machine that only gives a tiny bit of blast of CT to provide a better picture for your nuclear medicine camera. There's a gamut of nuclear medicine equipment. The wordage of this particular bill has defined all of this technology as a system designed to perform the function of both a nuclear medicine system and a computed tomography system. And the way it is currently written would require all of these types of equipment to have the same type of technologist operating that type of equipment. You would have to be doubly board-certified in nuclear medicine and CT to operate this type of equipment. The very low-end type of equipment would not require a board-certified CT technologist to run that type of equipment. And without getting very technical, I just wanted you to be aware that there is a whole gamut of types of equipment within this particular category and, again, it's a wordage problem that could be worked out in committee after this is settled but it needed to be addressed. So, in summary, we have three very important issues here. We need multiple pathways to achieve the goals for imaging professionals to become fusion

imagers through education and board certification. Board-certified CT technologists are equally qualified to perform CT on all CT equipment, and this is supported by all radiological fields including the ASRT, and nondiagnostic SPECT CT for attenuation correction type of equipment should be exempt from technologists having to be dual certified fusion technologists. I did include, as the last three pages, some change in wordage that I worked with the National ASRT on. It's wordage that they have used and suggested and endorsed, and I would endorse that type of wordage and is something that could be looked at. And I just wanted to say thank you for giving me the chance to speak on these issues and to see if you have any questions for me.

SENATOR BYARS: I presume, since I didn't understand two-thirds of what you told me (laughter)...

MARCIA HESS SMITH: I'm sorry.

SENATOR BYARS: No, it's not your fault, it's mine. Believe it or not, senators have small minds and we don't observe everything. But I presume you would be available to work with committee counsel and Senator Johnson's staff so we can try to get appropriate legislation, and with the Department of Health and Human Services.

MARCIA HESS SMITH: Absolutely.

SENATOR BYARS: Okay. I think everybody agrees we need to do something. It's a matter of getting all the language so that everybody understands what's necessary and not more than we need but...

MARCIA HESS SMITH: Right.

SENATOR BYARS: And you would be available to help?

MARCIA HESS SMITH: I would, absolutely.

SENATOR BYARS: I appreciate that.

SENATOR JENSEN: Yes, I think after this day, I'm convinced I'm ready to be term limited. (Laughter)

SENATOR BYARS: He was just joking. (Laughter)

SENATOR JENSEN: You know I do really believe though that from what you're saying and what we've experienced that I think we have to develop a system where there is a great deal more flexibility than we've ever had in the past. I mean x-rays are some day going to be obsolete. I absolutely believe that, as we know them today. And so, hopefully, we can come up with some kind of a system that is going to allow some of the many things that we talked about here today. And imaging is, boy, that's just a whole new field. The technology is so far ahead of, I think, what we're capable of even comprehending.

MARCIA HESS SMITH: It is. The technology that we talked about when developing our ethic of national consensus, you know, in 2002 even, has changed and it is difficult to keep up with. But I think that's important to try to keep as broad as possible when we do, and the language in this particular bill was very narrow.

SENATOR JENSEN: Thank you. Any questions from anyone else? Just a quick aside...I was a builder and developer. We had a shopping center and we leased some space to a chiropractor in 1970 and he moved in. And right next door we had a fish aquarium...a guy that sold fish. And he was in there for about three weeks and a lot of his fish started to die. (Laughter) And about that same time, I had a problem with my back and I went to down to see a chiropractor who was an older gentleman anyway, and he had this x-ray machine, I think from the 1920s...looked like a cannon...just huge. And it was pointed towards the wall, which was just a drywall wall, and he was killing the fish next door. Some were glowing, as a matter of fact. (Laughter) And I at least encouraged him to turn that thing around and shoot it into this dirt wall that was behind him but, wow. So I hope we're eliminating some of that stuff along the way here, too.

MARCIA HESS SMITH: (Laugh) Thank you very much.

SENATOR JENSEN: Thank you for your testimony. We appreciate it. Anyone else in...where are we, are we in

neutral? Okay.

RON JENSEN: Chairman Jensen and members of the committee, my name is Ron Jensen, and I am a registered lobbyist appearing in a neutral capacity on LB 882 on behalf of the Nebraska Association of Nurse Anesthetists. I just wanted to...I discussed this earlier this afternoon and had the opportunity to visit with Director Nelson about it. And I have a couple of questions about the section of the bill that adds "physicians assistants and nurse practitioners" to the practitioner language. And Director Nelson assures me that in using the term "nurse practitioner" they have sorted to the specific category of advanced practice nurses that they want to have this authority. I have two questions about that. One is factual and one's kind of rhetorical. One is on July 1, 2007, if I recall correctly, all of the advanced practice nurses in Nebraska become advanced practice registered nurses specializing in--so my question to Dick and to the committee is, if that term gets you to where you want to go today, is it going to get you there in July of 2007? And then the rhetorical question is this: If we're removing fluoroscopy and applying that only to ordering a plate, a radiograph, do we really want to make it that limiting or include advanced practice registered nurses? If you adopt the language that the department has suggested to you, from being around here for a number of years, think what you've done is sentenced all of us, the Legislature, the lobby, to spend the next 6, 8, 10 years piece by piece bringing the other specialties under the tent. I mean, all we're talking about is shooting a plate. And it seems to me that we could save a lot of time and money and heartache, maybe, if we just went ahead and put them all under it. That's all I'd have to say, Mr. Chairman. I'll answer questions if there are any.

SENATOR JENSEN: Any questions? I see none.

RON JENSEN: Thank you.

SENATOR JENSEN: Anyone else wishing to testify? Senator Johnson, do you want to close?

SENATOR JOHNSON: Senator Jensen, you reminded me, of your x-ray story, that when they redid the radiology department

and x-ray machines at the Douglas County Hospital many years ago, they discovered that the secretary was the fish. (Laugh) Now I don't think there's any reason to go on into any depth here. But I guess one of the good things that we've heard here this afternoon on this bill is that really there are no turf wars. What we really have are people trying to look ahead as to the best way to write the language so that when we do have these nuclear specimens and we go to MRIs rather than CT scans, for instance, that we're in a position to take care of that in advance rather than coming up with a new bill a year or two from now or whatever. So I'm optimistic and I'm sure that Director Nelson will work with these problems that we've illuminated today and go from there. So, thank you.

SENATOR JENSEN: Thank you. That will end the hearing.